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THE CHALLENGE OF IMPLEMENTATION

District Health Systems for Primary Health Care

World Health Organization

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December 1988.

This document builds on the background paper and on the report of the Interregional Meeting on Strengthening District Health Systems held in Harare in August 1987. It draws on a large number of documents from WHO and from other sources around the world. Valuable comments and suggestions on a draft were received from individuals both at WHO Headquarters and Regional Offices, as well as from other institutions.

Dr. Katja Janovsky has prepared this document for the Division of Strengthening Health Services.

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PART A
INTRODUCTION

Part A
1. Objectives and Structure of the Paper

What is this paper about?

This paper is concerned with the promotion of district health systems based on Primary Health Care. It reviews some of the key problems confronting the district, and describes the innovative and promising strategies that have been developed in a number of countries to address these problems. Its basic premise is that, to implement the visions of Alma Ata, we need to re-orient, re-organize and strengthen district health systems.

District health systems are not a new idea. Decentralization and central control have long been important political and organizational issues and strategies. Management of health services for defined geographical areas from regional, provincial or district centres has been a common feature of most health systems in developing and developed countries alike. What we are advocating here and now is a renewed effort to implement Primary Health Care and to strengthen the intermediate level in order to support and invigorate this effort. To succeed, Primary Health Care must have as its cornerstone a clear and firm national policy, and unwavering support from the top. But its full realization depends critically on the people in the district who are charged with the management and implementation of PHC strategies. It is in the district where top down and bottom up meet, if they are to meet at all.

The district provides an excellent organizational framework within which to introduce changes in the health system. At this level, policies, plans and practical realities can meet, and feasible solutions can be developed, provided that human and material resources are made available and sufficient authority is delegated.

Throughout this document, we address members of national authorities concerned with health systems management and delivery; people responsible for other sectors that are important for health, such as agriculture, education, environment and planning; regional and district health managers; donor agencies; and colleagues within WHO and other international agencies.

We hope that the paper will

- inspire supportive action for strengthening districts from national and regional levels;
- promote efforts to improve performance at the district level;
- guide strategy development and implementation planning;
- stimulate an increase in bilateral and multilateral funding for district development; and
- demonstrate WHO's interest and willingness to assist and support these efforts.

How is the paper organized?

This document builds on the background paper and on the report of the Inter-Regional Meeting on Strengthening District Health Systems based on Primary Health Care held in Harare in August 1987. In Part A, we first present a description of the district health system and its major elements. This is followed by a brief discussion of the essential preconditions that need to be in place for effective district health systems to develop and thrive.

Part B contains five chapters, one on each of the major elements of the district health system. We have called these major elements 'pillars', emphasizing their interdependent role as building blocks and structural support. They cover organization, planning and management; resource allocation and financing; intersectoral action; community involvement; and development of human resources.

The country experiences presented in these five chapters are an integral part of the text and form the core of the paper. Each of these chapters is organized according to a common format: Following a brief description of the pillar under review, some key problems are identified. We then explore issues arising from these problems and review the developments made in a number of countries in response to these issues. Specific attention is given to the practical steps that can be and have been taken so that others may learn, and adopt and adapt these strategies to their own circumstances. Each chapter ends with a set of conclusions about the problems and experiences presented.

In Part C, we draw together the conclusions and propose directions towards the formulation of a framework for action to guide both planners and implementers. The paper concludes by identifying a set of critical considerations that need to be addressed in the development, implementation and evaluation of any strategies adopted for strengthening district health systems based on Primary Health Care.

What are the limitations of the paper?

The pillars of the district health system described here have been identified over a long period of WHO involvement in many countries. They were used during the Inter-Regional Meeting on Strengthening District Health Systems in Harare in 1987, where they served as a useful framework for presenting issues and experiences. We have decided to maintain the same framework in this paper, although other classifications are, of course, possible.

We have not reviewed total country experiences of Primary Health Care development nor are we providing an historical analysis of the development of entire district health systems. Our approach has been to highlight specific aspects of district development rather than produce comprehensive cases.

Part A
2. District Health Systems: An Overview

What is a district health system?

The following definition of the district health system was adopted by the WHO Global Programme Committee in 1986:

> 'A district health system based on Primary Health Care is a more or less self-contained segment of the national health system. It comprises first and foremost a well-defined population, living within a clearly delineated administrative and geographical area, whether urban or rural. It includes all institutions and individuals providing health care in the district, whether governmental, social security, non-governmental, private, or traditional. A district health system, therefore, consists of a large variety of interrelated elements that contribute to health in homes, schools, work places, and communities, through the health and other related sectors. It includes self-care and all health care workers and facilities, up to and including the hospital at the first referral level and the appropriate laboratory, other diagnostic, and logistic support services. Its component elements need to be well coordinated by an officer assigned to this function in order to draw together all these elements and institutions into a fully comprehensive range of promotive, preventive, curative and rehabilitative health activities.'

Throughout this document, the term district is used in a generic sense to denote a clearly defined administrative area, which commonly has a population of betweeen 50,000 and 500,000, where some form of local government or administration takes over many of the responsibilities from central government sectors or departments, and where a general hospital for referral support exists. The actual organization of district health systems obviously depends on the specific situation in each country and each district, including the administrative structure and personalities involved. Nevertheless, the general principles for developing such systems are based on the Declaration of Alma Ata and the Global Strategy for Health For All, and incorporate the following:

- equity
- accessibility
- emphasis on promotion and prevention
- intersectoral action
- community involvement
- decentralization
- integration of health programmes
- coordination of separate health activities.

Why focus on the district?

Ten years ago, the call for 'Health for All by the Year 2000' led to massive political commitment around the world to the Primary Health Care approach. National Primary Health Care plans were formulated. In many countries, the development of a cadre of community health workers, often volunteers, became the key strategy for involving the communities in improving the health of their people. However, as more and more countries progress from the stage of formulation of national policies and plans for Health for All to their implementation, it is becoming apparent that the capability to plan and manage at the district level is weak and has hitherto not received adequate attention in the development of national Primary Health Care strategies.

Considerable progress has been made in extending coverage and in implementing selected programmes, most notably immunization. But in many countries, the situation is still characterized by a strong emphasis on medical services. The promotion of healthy practices and prevention of disease in the communities continues to receive considerably less emphasis than the care of sick individuals seeking help at health institutions. In the districts, epidemiological methods are rarely used to assess health status in the population and identify priority problems and vulnerable groups. The health sector remains a weak actor in the coordination of health-related activities within sectors such as agriculture, water development and education. Many of these weaknesses point to the need to strengthen capacity and capability in the districts for achieving Primary Health Care.

While we believe that the need for focusing on the district has become widely accepted, it is important to restate the reasons for, and the urgency of, this emphasis.

The district is the most appropriate level for coordinating top-down and bottom-up planning; for organizing community involvement in planning and implementation; and for improving the coordination of government and private health care. It is close enough to communities for problems and constraints at community level to be understood. Many key development sectors are represented at this level, thus facilitating intersectoral cooperation and the management of services across a broad front.

Country experiences show that health workers operating within and from their health posts and health centres cannot function in a sustained and purposeful manner without support. The most appropriate level from which to organize and provide that support is the district.

What are the key aspects?

In reviewing the district health system, we need to consider districts' vertical relationships with higher management levels, their horizontal relationships with local departments of other ministries, between different health programmes, and their external relationships with the communities and organizations they serve. It is, therefore, important to differentiate between district systems and the district level. District systems refer to the entirety of the district covering all elements and thus, all levels. The district level refers to the managerial stratum usually placed in the district capital that is hierarchically located between the national and regional or provincial levels and the communities. This level is also often referred to as the intermediate level.

The scope of the management responsibilities at the district level will depend to a considerable extent on the way political and executive authority is distributed, on the degree of decentralization that has taken place, and on the availability of qualified manpower.

As the responsibility and authority for promoting, implementing and supporting Primary Health Care becomes part of the district operation, close attention will need to be paid to those aspects which can be regarded as the main pillars of the district health system. These are:

- organization, planning and management
- financing and resource allocation
- intersectoral action
- community involvement
- development of human resources.

Organization, planning and management refers to the organizational structure and the managerial process for establishing Primary Health Care. This is a broad subject area and covers the roles, goals and responsibilities of different organizations and units in the district, programme planning, manpower planning, health and management information, monitoring and evaluation, coordination of programmes and activities within the health sector and with other non-governmental, private and community health organizations and agents, and the provision of drugs, supplies and transport. The development of systems and procedures, and their adaptation to the changing role of the district, are essential functions of management. Action research provides the means for finding practical solutions to operational problems and is, therefore, an essential ingredient in the development of strategies and plans, and in monitoring and evaluating the cost and the effectiveness of different interventions and activities.

Financing and resource allocation are part of planning and management. They are addressed separately to denote their key role in developing and sustaining health services. They are highlighted to draw attention to the need for the district to take an active role in resource allocation decisions, identification of sources of financing and development of useful financial information systems.

Intersectoral action in the district concerns the promotion and coordination of different sectors' contributions to health and improvement of the quality of life. It covers environmental changes, such as clean water, improved sanitation and housing, better food supplies and the raising of income and educational levels as means of improving health. Achieving equity and reaching vulnerable groups are critical issues that require intersectoral perspectives and collaboration.

Community involvement addresses itself to the task of mobilization, putting in motion a widespread process of collective organization and involvement which leads to increased human and material resources at the local level being channeled into development efforts. It seeks to create support

mechanisms in order to establish the preconditions for full participation and to clear the way for the required changes. It is also concerned with community health workers and with other change agents in the community.

Development of human resources for district health systems based on Primary Health Care requires a comprehensive manpower policy for the entire system, from the definition of manpower needs through basic training orientation, career development and working conditions. In the district, human resource development is concerned with the provision of relevant in-service training and support and supervision, and the re-orientation of health workers based on competency profiles rather than on outdated duty schedules. It seeks to narrow the gap between managing and training for Primary Health Care, and to develop procedures, methodologies and materials that fit the requirements of the district.

The next chapter considers preconditions for district development that need to be addressed at the national level.

Part A
3. Preconditions: Decentralization and National Support

For district health systems to function effectively, a number of essential conditions need to be met. This is not to say that districts cannot function in the absence of these conditions; however, the opportunity for significant change will be lessened and the effectiveness of planning for implementation much impaired, if they are not in place.

District health systems cannot fully develop without commitment and support from the national level, or without some degree of autonomy and authority for planning services, for allocating financial resources and for managing human resources. Although decentralization in name has been effected in many countries, district health managers are rarely given sufficient authority in decision-making and resource allocation for effective district-based planning and management. These are preconditions for functioning district health systems which underscore the fact that districts are part of the national health system, and that the two are interdependent.

At the policy level, this interdependence implies the need for an overall national plan for Primary Health Care which defines policies and broad strategies. Such a plan is essential if districts are to develop Primary Health Care in a coordinated way, and if equity is to be assured from the national perspective. Commitment to the Primary Health Care plan is needed, not only of the Ministry of Health but also of all other relevant sectors and agencies in the country.

The most important policy directive concerns the decentralization of the national health system in such a way that functional district health systems can result. This requires the provision of the necessary financial and manpower resources to the district; and the development and implementation of broad guidelines that encourage adherence to the adopted strategy while allowing sufficient flexibility to adapt the overall plan to suit local circumstances. Such guidelines can provide a formal link between different levels and encourage dialogue about lessons learned. They need to specify the role and responsibility of the district, covering organization, planning and management; research; financing and resource allocation; intersectoral action; community involvement; and human resource development. Central managers need to regularly review the guidelines and be prepared to modify aspects of the national strategy based on experience gained in the districts.

As a result of decentralization, roles and responsibilities change significantly not only at the district level, but at the central level as well. Central and, where applicable, regional staff need to re-orient their work from exercising managerial control as line managers to providing professional support as technical advisors. Decentralization requires that central and regional managers place more emphasis on overall resource allocation and financial management and less on the details of service provision. Within the confines of the budget (from national and local sources) and in accordance with overall policy, the district manager takes the decisions and negotiates cooperation concerning health in the district.

A forthcoming WHO document (Decentralization and Health for All Strategy), describes a common pattern of roles and responsibilities, as management functions are decentralized:

Ministry of Health is responsible for
- health policy formulation, including policy on intersectoral activities
- production of national health plans and regional and local planning guidelines
- advisory role on allocation of resources, particularly capital funds
- source of high level technical advice for specific programmes
- control over purchasing pharmaceuticals and distribution of supplies
- training and regulation of health manpower development
- regulation of private profit and non-profit health organizations
- control of national health organizations and research institutes
- liaison with international health organizations and aid agencies.

Regions and/or Provinces are responsible for
- regional health planning and programme monitoring
- coordination of all regional health activities
- employment and control of part or all of the health manpower
- budgeting and auditing of health expenditure
- approval and financing of large scale capital projects
- managerial and technical supervision of district health teams and district heads of specific health programmes
- provision of supplies and other logistical support.

Districts are given the following main functions:
- organization and running of the district hospital services
- management of all other government health facilities
- implementation of all community-based health programmes
- management and control over local health budgets
- coordination and supervision of all government, non-government and private health services within the district
- promotion of active links with local government departments
- promotion of community participation in local health service planning
- preparation of an annual health plan
- raising additional local funds
- in-service training of health workers
- supervision and control of all community health workers in the district
- collection and compilation of routine health information and forwarding it to regions and ministries of health.

Local communities may undertake the following functions:
- recruitment, payment and supervision of community health workers and trained traditional birth attendants
- provision of community finances toward the cost of health services
- participation in local health planning initiatives and the contribution of labour and materials for the construction of clinics and staff housing
- organization of preventive health care, particularly activities concerned with mother and child health, immunization and oral rehydration.

Establishing a Process for Translating Policies into Strategies and Operational Plans

Broad policy statements may be made by the president of a country or by other politicians. Official documents and plans tend to contain equally broad statements and resolutions. However, there is usually no effective mechanism in ministries of health whereby these broad statements can be analysed and specific objectives and strategies developed. As a result, implementation is not adequately guided and supported. There are instances, however, where countries have developed a participatory process for translating policies into implementable plans.

PLANNING FOR IMPLEMENTATION IN ZAMBIA

In Zambia, the Ministry of Health produced guidelines based on a series of proposals for implementing Primary Health Care, spelling out in detail how the programme would be organized at all levels of the system. The guidelines also dealt with the basic principles of Primary Health Care and outlined how these were to be incorporated in the operational plans. Over a period of one year, a series of small workshops was held in the districts to produce the plans that made up the master guidelines, culminating in a national workshop with representation from all levels to discuss and adopt the masterplan for Primary Health Care.

Source: WHO Travel Report, 1985.

Managing Decentralization

Experience shows that where decentralization has been effected abruptly, with wide-reaching powers handed over to the regional or district level without adequate preparation for the transfer of responsibility and authority, the effectiveness of the district system can be severely impeded. On the other hand, there is evidence that the acceptance of responsibility and adaptation to a new role is greatly facilitated by actually having been given power. The reverse happens more frequently, however: District managers are given a great deal of management and leadership training, only to return to a situation where they do not have the authority required to effectively apply their newly acquired management and decision-making skills. The result is frequently frustration, followed by lethargy.

THE PAPUA NEW GUINEA EXPERIENCE OF DECENTRALIZATION

In 1976, shortly after independence, the government of Papua New Guinea passed a constitutional law which laid the basis for decentralization and set down the authority of the provincial governments, their areas of responsibility and their relationships with the national government and the national public service. Today, Papua New Guinea has twenty provinces, each with their own government and administrations.

Rural health services were fully decentralized to provincial governments, and finances were passed to the provinces in the form of unconditional grants. Responsibility for the provincial hospital, disease control and environmental health programmes was delegated by the national government to the provincial governments, with adequate finances directly earmarked for these activities. The budgets were originally agreed between the provincial governments, the national department of health and the department of finance. Later, it was agreed that negotiations could take place directly between the provinces and the department of finance.

Early on in the implementation of decentralization of health services, senior national staff were strongly opposed to devolving their administrative authority to staff in the provinces, and to the full decentralization of budgetary controls over health activities. In several provinces, the selected leadership was weak and local staff unprepared for their increased responsibilities. The national health department instigated in-service training to help overcome some of the weaknesses, but it was up to the provinces to decide whether or not to take advantage of this training.

Although the administrative role of the national health department considerably decreased following decentralization, its importance as a technical advisory body was substantially enhanced. But many senior programme heads at national level found it very difficult to change from being in charge to being technical advisors to provincial programmes. Gradually, however, the national health department began to revitalize its technical competence, and its ability to assist and guide provincial programmes has greatly increased. As a result, there is now greater demand for central support and advice than was the case initially.

To facilitate the technical input from the national level, four regional offices were set up where epidemiologists, disease control officers and nutritionists were located. The role of these offices remains purely advisory, however.

The national level retains responsibility for overall health policies which are to be implemented by the provincial departments of health. The national health department, therefore, has a strong supervisory role in ensuring health policies are followed throughout the country.

Because the decentralization process in Papua New Guinea was politically determined, its rate of implementation could not be altered to follow administrative requirements. If decentralization had occurred over a longer period of time, perhaps many of the problems encountered with leadership could have been overcome. The initial reluctance to decentralize by the national health department delayed the organization and caused a backlash against the department by the provinces which later had to be overcome.

Source: Mills, A. et al. Decentralization and Health for All Strategy (in preparation).

Evaluating Decentralization

Decentralization, like any other organizational change, needs to be carefully monitored and evaluated to ensure that the desired results are achieved and that side effects are considered and addressed.

Within a broad-based legal framework, it is important to allow flexibility for execution so that lessons learned in the implementation of decentralized systems can lead to modifications and changes, as required.

AN EARLY ASSESSMENT OF DECENTRALIZATION IN MEXICO

In Mexico, full decentralization has been effected in fourteen of the country's 31 states where it is based both on state health laws and on various presidential decrees issued in 1983 and 1984.

In April 1987, a preliminary assessment of the situation produced the following main findings:

- the potential for improvement created by the decentralization is rapidly being realized through the reorientation of staff towards outreach community health work, under the leadership of highly motivated state health teams;

- the rationalization process has greater scope and impact due to the merger of all health care organizations for the non-insured population in each state;

- the decentralization of the operational budget and of personnel management greatly increases the effectiveness, efficiency and transparency in the use of resources, and the credibility of the health sector vis-à-vis the other state and municipal authorities. An important by-product is the increase in managerial capabilities of the state health teams, who can now 'learn by doing';

- health promotion is now stronger in respect to the governors, mayors and other policy-makers at the state and municipal levels; resources from these levels and also from the federal government are being made available in greater amounts and their use is better oriented towards priority needs.

- intrasectoral coordination (with social security) and intersectoral cooperation are facilitated by decentralization and the enhanced status of the state health authority that goes with it. This coordination takes place in the state development planning commitee and in the municipal health sub-committee.

Source: The Process of Decentralization of the Health System to the State Level and the Organization of Health Districts in Mexico, 1987

PART B
THE PILLARS OF THE DISTRICT HEALTH SYSTEM

Part B
4. Organization, Planning and Management

Organization, planning and management is a broad subject area and covers the organizational structure and the managerial process for establishing Primary Health Care. It includes programme planning and budgeting; manpower planning; health and management information; monitoring and evaluation; coordination of programmes and activities within the health sector and with other non-governmental, private and community health organizations and agents; and the provision of drugs, supplies and transport. The development of systems and procedures, and their adaptation to the changing role of the district, are essential functions of management.

Action research is considered an integral part of planning and management. It provides the means for finding practical solutions to operational problems and is, therefore, an essential ingredient in the development of strategies and plans, and in monitoring and evaluating the cost and the effectiveness of different interventions and activities.

SOME KEY PROBLEMS

- **Roles, goals and procedures at the district level are often poorly defined.**
- **Organization, planning and management expertise is commonly weak in the district.**
- **Difficulties with integrating vertical programmes into a comprehensive district implementation plan persist. This is also true at the health facility level where special clinics continue to feature instead of integrated services.**
- **Much routinely collected health information is not analysed and utilized. At the same time, information required for decision-making and monitoring is not systematically collected. Most national information systems do not adequately highlight the information required by district health teams for managing and for evaluating Primary Health Care.**
- **Health systems review and research are frequently carried out by consultants, academics or headquarters staff, without much involvement of the people who need to take decisions and implement the changes indicated by research findings. As a result, studies are often not appropriately oriented and sufficiently practical to be of use in improving district health systems.**
- **Little use is made of systematic analysis of problems and testing of solutions as an approach to problem-solving by district teams.**
- **Communication and collaboration between communities and hospitals, health centres and local programmes in support of Primary Health Care remain weak.**
- **The role of hospitals and the orientation of their staff continue to be clinical and static in nature.**
- **Logistical support in the district is unsystematic and weak. While mobility is essential to provide support and supervision and to develop effective outreach programmes, transport management is virtually non-existent, and the skills and spare parts to repair and maintain vehicles, motorbikes and bicycles are usually lacking at the district level.**

Management Systems Development and Training

There has been considerable debate in the field of health systems management concerning the relative merits of structural reform and of training. The acquisition of knowledge and skills is an important part of management development. But there is growing scepticism concerning the effectiveness of training alone unless greater emphasis is given to improving the environment in which managers have to work. Although training is generally used as the entry point for bringing about change, it is increasingly recognized that most problems need a certain degree of structural reform as well as additional skills.

Structural reform and systems development usually require national action, but the participation of district managers in this process is essential, if the resulting reforms are to address problems most felt at the local level.

National facilitators, who can assist district health teams in the systematic examination of problems and preparation of action plans to solve these problems, have been trained in a number of countries. Once a critical mass of facilitators has been trained, they form a permanent network of resource people who can help in planning and managing change.

REGIONAL HEALTH MANAGEMENT DEVELOPMENT NETWORK IN THE SOUTH PACIFIC

The Regional Health Management Development Network was started in 1983 as an inter-country project of a number of Pacific islands. The key emphasis was the integration of activities aimed at improving management systems and developing human resources. It was recognized that management systems developed by external experts are often not implemented because national staff have not been sufficiently involved in their development. Consequently, the systems are often not well understood and unsuitable for local conditions. The project utilized an approach designed to bridge this common gap in management development. It involved national staff in the review of policies and procedures affecting their operations, thus enhancing the analytical and managerial capabilities of national staff and leading to the design of improved health management and support systems.

Guidance and support were provided through technical and training inputs by consultants. The technical input contained definitions of the system selected for review. It also included criteria for determining the requirements of the system and its operational efficiency and effectiveness.

The training input provided a set of structured activities designed to help the national staff operating within the system under review to identify major deficiencies, and to enable them to design improved management procedures. The activities were proceduralized in ways which enhance their use in relation to different systems.

In order to permit adequate coverage, promote self-reliance and sustain the developmental activity over time, local facilitators were trained and utilized. These facilitators took increasing responsibility for conducting workshops and other review activities by using procedures and guidelines developed for this project.

The health management development project has developed a core of national staff to assist in the systematic examination of technical and administrative problems in their areas of responsibility and to prepare

plans of action to solve these problems. But there is now increasing concern that the continued development and long-term support of these initiatives can only be maintained if district-level management capabilities are also strengthened. Toward this end, a follow-up project is now under preparation.

Sources: Report on the Third Meeting of National Facilitators of the Regional Health Management Development Network, 1986.
Rotem, A. Health Management Development Network, A Handbook for Facilitators, 1987.
Strategies for PHC Development in the South Pacific, 1987.

A number of countries have implemented district management development and training strategies that are combining systems development with activity-based learning (see also chapter eight). Often, these activities are organized around the annual planning and budgeting process. Although workshops and seminars continue to be the most frequently used method, an increasing number of countries are complementing this approach with problem-solving assignments and follow-up visits to review progress made.

HEALTH PLANNING AND MANAGEMENT WORKSHOPS IN KENYA

In 1982, the Ministry of Health began to hold a series of planning workshops with national and provincial managers to create greater awareness and familiarization with decentralized planning principles and guidelines. During these workshops, criteria for planning, data requirements and training needs were discussed. Based on these discussions, a programme of district level workshops in management and planning was subsequently established.

The approach to strengthening the managerial performance of district teams was developed as part of a national continuing education programme. In this programme, participants were treated as members of a working team. The most valuable resource was the team's own working experience. It was the facilitator's role to focus and help interpret this experience. The programme had a two-pronged approach:

- training organized in workshops with active participation by all team members; and

- post-workshop assignments completed by the teams — supported and followed up by the provincial health management teams and facilitators.

After attending the first workshop, participants were expected to be able to

- carry out problem-preventing and problem-solving activities,
- know and be able to apply basic principles of management, including systems approach, group working, organization and coordination, communication and motivation, delegation, supervision and leadership,
- apply the knowledge and skills acquired in the workshops,
- share their knowledge and skills with their staff.

A second series of workshops on planning for district health teams was run with the following objectives:

- to orient district officers to the concept of district participation in developing the national five-year development plan,
- to review and discuss Ministry of Health strategy statements,
- to identify data and data sources needed for district plans,
- to identify district constraints and determine needs for further help in preparing district plans.

A final series of workshops emphasised supervisory principles, structure and procedures. A module on annual planning and budgeting was linked into the government cycle of annual estimates and budget allocations.

At the end of the programme, an evaluation was carried out showing that

- the two-pronged approach combining formal training with practical working assignments was highly effective in transferring classroom learning to the workplace,
- problem-solving workshops led to improvements at work, more efficient use of time, increased motivation and better job satisfaction,
- the training helped district teams to accept increased managerial responsibility,
- initiation of team-work and clarification of individual roles and responsibilities led to noticeable improvements in daily work,
- patients and local leaders expressed their appreciation of improved health services.

Source: Ranken, J. Approaches to Systematic Management Development for Primary Health Care by Ministries of Health, 1987.

In order to adequately prepare district, regional and national staff for the changes in their roles and responsibilities following decentralization, a number of countries have implemented orientation and training programmes aimed at strengthening different levels of the health system (see also chapter eight).

DEVELOPING DISTRICT HEALTH SYSTEMS IN DEMOCRATIC YEMEN

The main thrust of the Government's policy for health development in the People's Democratic Republic of Yemen is to increase not only the coverage of health services through primary health care, but also to decentralize responsibility for the implementation and the integration of the different elements of PHC.

This process requires a strengthening at the different levels of the health system of the capacity for planning, programme budgeting, management, coordination, supervision, monitoring and evaluation. In 1986, the government decided to select a number of districts for special study and development of strategies for mobilization by Government, party and the mass organizations. This programme of strengthening districts for effective decentralization has the following components:

- Training and re-orientation of the key managers of each district and of the key support staff at central level

- Establishment of permanent links between the local People's Committees (primarily responsible for the mobilization of popular support for and involvement in government's policies and programmes); and the development of local objectives and priorities for health development

- Training of a sufficient number of staff in each district in health systems management

- Establishment of effective mechanisms at district and community level for planning and management of health and health-related activities.

The process is seen as a 'learning by doing' approach, both at local and central level. Monitoring and evaluation have been carefully planned from the beginning so as to facilitate the learning process.

Source: WHO Travel Report, 1987.

Action Research

There are differing views over what is meant by action research. The term is taken here to mean a programme of developing and testing improvements to existing health systems. It uses both quantitative and qualitative methods. It seeks better action approaches, not necessarily optimal ones. It pertains to problem-solving as well as to the identification of opportunities. It addresses one-time questions, as well as iterative cycles of test-revise-test. It includes analytic studies, field interventions and experimental trials. Most importantly, action research can and should involve the people working in the system or on the problem under review.

Problem-oriented action research is an important strategy for overcoming the weakness of management systems and for improving the performance of managers as individuals and teams.

PROBLEM-ORIENTED ACTION RESEARCH IN MALAYSIA

The Director General of Health Services in Malaysia had recognized for some time that many of the problems reported by his state and district officers could be solved through improved efforts of health service staff at those levels. Instead, attempts at problem solving consisted of requests for more resources and proposals for staff expansion. In 1986, he called upon the Institute of Public Health to develop an action research approach to problem-solving. District health teams became the focal point of this exercise which encompassed a nine-month period. The following steps were undertaken:

- Decisionmakers within the Ministry of Health selected four states which they felt could benefit by participating in a problem-solving effort; and selected four specific service problems, one to be assigned to each state/district team.

- The Institute of Public Health designed and conducted a nine-day workshop during which each state/district team was assisted in designing their proposals for solving the assigned problem.

- Each state/district team then undertook, within a defined area, the implementation of their solution.

- Each team carried out a pre-designed evaluation of their progress and problems in implementing their solution.

- Teams then came together for a three-day evaluation workshop in which they presented the results of their individual evaluations.

Thus, the process combined a variety of managerial tasks within an actual service improvement effort which included a variety of forms of action research. Teams participated in short highly participative workshops in which they learned through practice certain techniques in planning and evaluation. But it was the overall process of problem-solving by a team effort that was intended to provide the major learning opportunity.

The results of this approach were impressive. For example, in Temerluh District, a master immunization register was established which ensures that all births and scheduled immunizations are recorded. Special defaulter follow-up procedures were instituted including mailed reminders of immunizations due, home visiting and closer supervision. As a result, third dose DPT coverage increased from 47 to 61%, TA/DA/polio booster increased from 14 to 28% and measles immunization coverage rose from 13 to 41%. In Kelantan State, intensive staff training and community level health education resulted in increasing the annual blood examination rate for malaria parasites from 410 to 717 per 1000. The major increase was achieved through the efforts of MCH staff nurses (increasing on average from 3 to 31 slides per month) and through PHC efforts in schools (from 13 to 29 slides per month).

The approach continues to be successfully employed in Malaysia. But instead of being assigned specific problems, district teams are now actively involved in identifying the problems they consider a priority in their area.

Source: Sapirie, S.A., Action Health Systems Research through District Health Team Problem-Solving, The Malaysian Experience, 1987.

The WHO Primary Health Care Joint Review is another useful approach and provides tools for systematic review of the performance of health systems. Development of PHC Joint Reviews started in 1980 in response to an urgent need for a process which, over a short period of time, would yield comprehensive information about PHC implementation, scientifically valid and representative of the country as a whole. The reviews are carried out by ministries of health in collaboration with other relevant ministries and agencies, and WHO. A set of modules is used to assess different aspects of Primary Health Care, depending on the information needs and particular interests of the country and the participants. Although initially intended primarily for national decision-makers, this methodology can be readily adapted to address the information needs at the district level, since investigations are primarily carried out in the districts with the district health teams. Primary Health Care Reviews have been conducted in some 35 countries, and as experience is gained, the methodology continues to be modified and strengthened.

Experimentation with innovative strategies is another form of action research which has been applied with good results in several countries. Often, experimentation does not involve new technical solutions but is concerned with developing and testing more effective ways of implementing already known strategies.

STRATIFICATION OF HEALTH CENTRES AND DISTRICTS IN INDONESIA

Stratification of health centres has been developed as a managerial tool for the assessment of functional development and performance of health centres in Indonesia since 1979.

All health centres, sub-health centres and mobile health centres in the country are classified into three groups according to their scores on a number of selected standard variables. The scores are indicators of performance, achievements and resources in the following areas:

- programme activities
- planning, management and evaluation
- health facilities and manpower
- environment.

In 1984, the stratification of health centres became a national policy and is now being implemented throughout the country. Health centres with excellent performance are placed in Strata 1, those with standard performance in Strata 2, and those with sub-standard performance in Strata 3.

The country is divided into three regions based on the development of status of different parts of the country. In the most developed region, health centres in Strata 1 must have scores above 75% whereas in the least developed they only need a score above 50% in order to be classified as Strata 1.

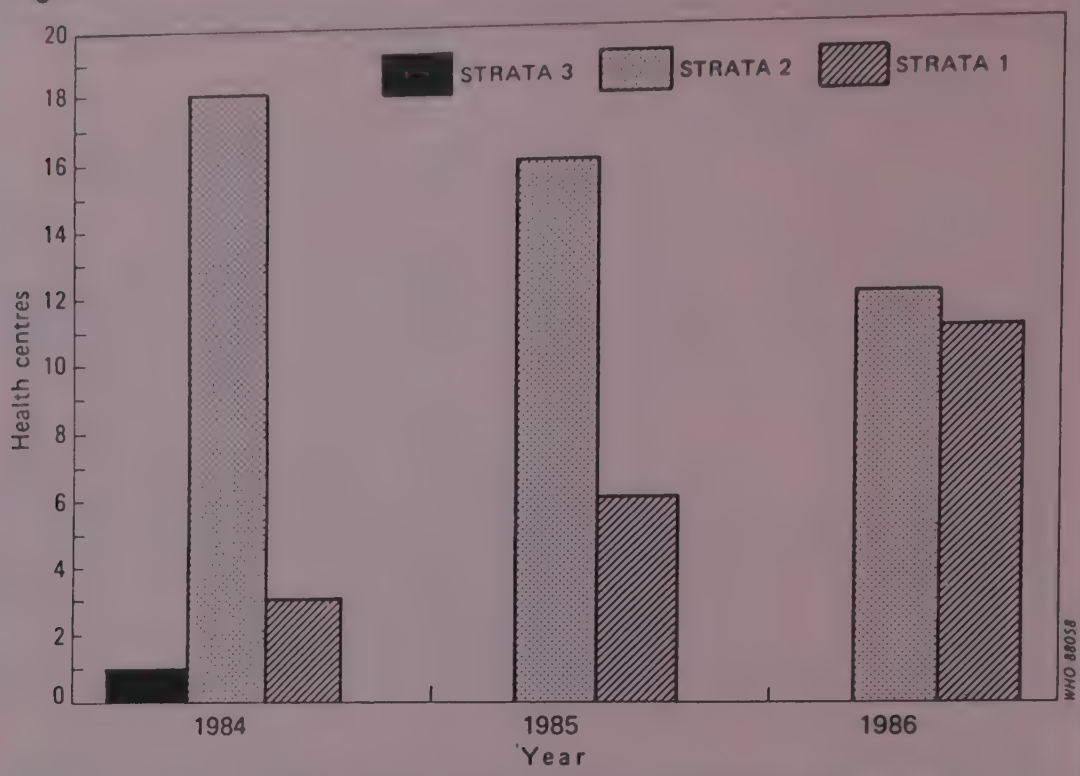
Stratification takes place once a year. Once results are obtained, health centres can immediately decide on remedial measures without waiting for feedback from higher levels. The district level checks the validity of the data and takes decisions for necessary support and follow-up supervision on a short and medium term basis. Maps and charts are prepared for all health centres in the district. The results are sent to the provincial level and from there to the central level.

Competitions among the health centres are carried out to stimulate their activities. Strata 1 health centres are used as models for others and serve as training centres. Model health centre doctors and model para-medical staff are also selected.

In 1986, some provinces started to use a similar instrument to evaluate the performance of the districts. Sidoarjo District where health centre stratification has been going on since 1979, was the first district in East Java to receive a trophy for best district performance.

The following figure shows Sidoarjo's record of health centre stratification over three years during which the number of Strata 1 health centres more than tripled.

Figure 1



Sources: Halim Kesuma, et al, Profile of District Health Services, Sidoarjo District, Indonesia, 1987.
Yahya, S., Strengthening of Health Centres through Stratification, Micro Planning and Mini Workshops, 1986.

The establishment of an action-oriented research capability within a Ministry of Health can address both the problem of relevance of the research conducted and the issue of utilization of results. The quality of action research conducted by ministries may be enhanced by forging close links with university institutes and other research-oriented bodies.

BOTSWANA: HEALTH SYSTEMS RESEARCH AS A TOOL FOR DISTRICT LEVEL HEALTH PLANNING AND MANAGEMENT

In 1984, a health research and development conference held in Gabarone brought together policy-makers from the Government of Botswana, the major institutions that had been involved in health related research and the various donor agencies that had supported research and development in the country. This conference was a milestone in the development of health research in Botswana. It sensitized policy-makers to the potential of health systems research as a management tool and contributed toward the coordinated development of research to support the national health development process. Simultaneously, a multidisciplinary Health Research and Development Committee (HRDC) was established and this committee has played a crucial role in promoting and supporting health systems research in the country. It set up research priorities in line with national goals and health needs, and actively involved itself in strengthening institutional and individual research capabilities in the country through the efforts of committee members who supervise, guide and support beginners in the field.

A Health Research Unit was established within the Ministry of Health in August 1985 and serves as the secretariat to HRDC. It initiates, coordinates and supports training and research efforts in the country.

Also, it has spearheaded the development of strategies and the implementation of plans to integrate the use of health systems research as a management tool in the health services. In particular, the Unit has helped develop the capacity of district health teams to conduct operational research and use its findings as part of their day-to-day work. The Unit provides training, support and guidance to district teams for the planning and execution of projects. It assists districts with the organization of seminars and with publications to disseminate study results. Follow-up activities to promote and monitor the utilization of findings are an integral part of the Unit's work in the district.

A number of factors have contributed toward the process of development of health systems research in Botswana:

- a strong and continued personal commitment to health systems research by the highest executive in the Ministry of Health
- a clear policy that has enabled research policies to be defined and research efforts to be coordinated
- a focal point for the coordination and promotion of health services research in the Health Research Unit
- the position of the Health Research Unit in the MoH structure reporting directly to the Permanent Secretary
- the prevailing district focus in health policy
- a sustained effort to train and support health personnel in doing health systems research and using its findings to improve the health of the people
- the recognition that time for health systems research must be included in the annual district work plan in the same way as time for workshops and training.

Source: Owuor-Omondi, L., The Development of Health Systems Research as a Tool for District Level Health Planning and Management, The Case of Botswana, 1987.

Strengthening Health and Management Information Systems

Conventional health information systems were developed within health services of a different nature from those which are evolving based upon the principles of Primary Health Care. They were conceived as a way of providing information for the planning and control of health services from the national level, to enable the passive administration of the health services, or at least the part under government control. The data collected in such conventional systems generally passes from the periphery of the health system, where it is collected, to the national level. It may be aggregated on the way at the district, but it usually plays little or no part in the day-to-day management of the district health system.

Information support is needed in the district to assist health management teams in

- assessing health needs in the district
- implementation planning
- controlling key resources
- monitoring programmes and taking corrective action when necessary
- evaluating programmes.

District health managers need to review their information needs and expand their sources of information. Whether the impetus for such an information review comes from within the district or from the national level, it is likely that programme managers and other national officers will be in a position to support such assessments and help plan the use of information. In a number of countries, efforts to develop information support in the context of general health management development have led to considerable improvements in the provision of appropriate, decision-linked information for the district as well as the national level.

MANAGEMENT SUPPORT TO PROVINCES IN PAPUA NEW GUINEA

The 1986–1990 National Health Plan of Papua New Guinea identifies management as one of the main constraints on the continued development of health services at all levels. The need for management development is described as particularly urgent at the provincial level where the responsibilities of staff have substantially increased since decentralization. While a few of the top staff at the provincial level have undergone further training in management, most have been given increased responsibility without adequate preparatory training and experience.

In order to address the management deficiencies at the provincial health division level, the Department of Health formed a Managerial Support for Provinces (MSP) Coordinating Group in June 1986. To develop a sound basis for the introduction of a management development and support system, a situation analysis was undertaken by gathering information in four main areas:

- political and administrative structures
- components of the health care system
- organizational structure of department of health and provincial health division services
- operational management responsibilities at the provincial level including planning.

Management assessment visits to each province were undertaken, investigating personnel management, resource management, budgeting, information system development, supervision, planning and quality assurance. An assessment checklist was developed to gather uniform information through individual and group interviews with staff, examination of records and data, and discussions with provincial administrative and field staff outside the health sector.

The objectives of these initial visits were to gather information, become acquainted with the provincial health staff, assess the need for management development, conduct an in-service session on understanding and using health information, and determine the provinces' interest in participating in the MSP programme.

The assessment visits were completed in February 1987. After reviewing and synthesizing the assessment visit checklists and reports, the following areas of management development were identified as having the greatest priority in the provinces:

- information systems development
- development of annual and of five year provincial health plans
- development of approaches and tools for proper support and supervision of health centres.

It was decided that there was a need to develop training modules which could be used as distance learning tools by provincial staff without outside facilitator.

The key element of the Management Support to Provinces programme, however, is the follow-up visits. Each province is visited three times a year by the same MSP Coordinating Group member. During the visit, time is spent with individual section heads to review progress since the last visit. An in-service education session is held and objectives are set for areas to be worked on by the provincial staff prior to the next support

visit. Thus, it is an iterative process of the MSP member and provincial staff jointly setting objectives for management areas and provincial staff working towards these objectives over a three to four-months period, followed by another MSP visit to review progress, discuss problems, investigate alternatives, and to set new short-term objectives for the next visit.

Source: Newbrander, W.V. et al, Managerial Support for Provinces: A Programme for Developing Provincial Health Management Capabilities in Papua New Guinea, 1988.

Developing Plans and Setting Targets

To develop and sustain the commitment of the district health team and other health workers to achieving the goals and objectives of the health system, their involvement in planning health services and action is essential. Sharing the strategic vision of an organization's mission and setting up a process for translating that vision into concrete plans for implementation is an essential element of leadership and of participative management. This entails

- wide dissemination of information about national priorities, goals, objectives and strategies;
- participation of health providers and clients in the process of problem identification and problem definition
- formulation of district health plans;
- development and use of operational work plans that specify activities, targets and the time frame within which they have to be fulfilled, as well as assigning clear responsibilities to teams and individual workers;
- developing managerial styles that facilitate a free flow of information in all directions.

SETTING TARGETS FOR HEALTH IN NORWAY

In November 1985, a conference was held in Norway to discuss challenges to planning after decentralizing Primary Health services to local municipalities. During this conference, the minister for social affairs for the first time publicly declared the Norwegian commitment to the HFA strategy and also stated that the government would prepare a National Health Plan.

Subsequently, the National Association of Municipalities, with support from the directorate of health and the ministry of social affairs, prepared a series of conferences with the aim of translating the HFA policy to the district level and providing the counties and municipalities with a new planning tool based on HFA principles.

The basic elements of the national health policy are described as follows:

1. There are twelve **problem areas** which emerge from epidemiological studies; these give rise to twelve outcome targets
   - reduce inequity
   - develop and use health potential
   - reduce consequences of disability
   - reduce amount of disability

- reduce specific diseases
- increase life expectancy
- reduce infant mortality
- reduce maternal mortality
- reduce mortality from diseases of circulatory system
- reduce mortality from cancer
- reduce deaths from accidents
- reverse rising trends in suicides.

2. These targets cannot be achieved by work within the health sector alone. Five **areas of concern** are identified:
- health care system
- lifestyles
- environmental risks
- information and research
- political support.

3. There are six **basic principles** to be kept in mind at all times to prevent contradictions within the system:
- equity
- community participation
- health promotion
- multisectoral cooperation
- international cooperation
- focus on primary health care.

4. Within each area of concern, there are specific objectives which will assist in the realisation of the outcome targets. Three **methods of work** are common to all areas of concern and consist of
- information
- cooperation or network building
- policy: resource allocation and/or regulations.

With the help of this framework, Norway has started a process of joint planning between the centre and the municipalities, and between health providers and health consumers. The process starts from the vantage point of the target group which is to experience improvement. It is at the local level where planners, health professionals and members of the public need to decide which of the outcome targets are most relevant to the health of the most important target groups, which areas of concern are most relevant, which are the most suitable partners in cooperation, how to use information, how to allocate resources and, finally, how to proceed.

Source: Kromberg, M., Target Setting and Development of Information Systems in Districts, 1987.

Reassessing the Role of Hospitals in Primary Health Care

In its 1987 report, the Expert Committee on Hospitals and Health For All suggests that there tends to be an in-built bias at hospitals in favour of institution-based services. Community-oriented services are considered to be quite separate from hospitals and sometimes even in competition or conflict with them. These differences have their roots in differences of technology, function and values. Hospital activity focuses on individual sophisticated technologies and intensive treatment. It is often fast-paced, dramatic, and short-term. It requires professional control and dependence of the patient on the provider. Primary Health Care activities focus on populations as well as individuals, and on simple methods of treatment and prevention; people are required to be self-reliant and less dependent upon the providers. The traditional separation between the two types of activity forms an important barrier to functional coordination.

The Expert Committee recommended that hospitals at the first referral level:

- re-examine their own role in the district health system;
- consider how they could become more integrated with other partners in the district health system;
- involve hospital personnel whenever possible in Primary Health Care outside the hospital;
- develop orientation and training programmes that strengthen their staff interests and roles in Primary Health Care;
- consider how financing and resource allocation methods might be developed so as best to meet the needs of the entire population;
- consider how clinical referral systems can be made to function more effectively, including ways in which the hospital can support the more peripheral health units, thus increasing the confidence of the community in them and strengthening the health system as a whole.

A number of non-governmental organizations have introduced highly effective community outreach programmes supported and supervised from hospitals. But nationwide re-orientation of government hospitals to support Primary Health Care has remained an elusive goal so far.

Developing a District Capability for Preventive Maintenance and Simple Repair of Vehicles and Equipment

There is general lack of understanding that the total cost of equipment is much greater than the cost of purchase. Over the expected life-time of equipment, the expenditure on maintenance, repairs and consumable items usually greatly exceeds the purchase price. Although the problem needs to be tackled at the national level by developing an overall strategy for equipment management, districts can start by orienting health workers towards preventive maintenance of essential equipment. Equipment checks and in-service hands-on training for simple repairs are usually an integral part of the support and supervision protocols of special programmes, such as Expanded Immunization.

Transport is an integral and essential component of logistic support to Primary Health Care. It affects not only the outreach possibilities of services, but also supervision, in-service training, referral and supplies. The effect of a poorly functioning transport system is to reduce the quality of care as well as the coverage.

The 1985 Inter-Regional Meeting on the Development and Strengthening of Logistic Support to Primary Health Care suggested that vehicle standardization is an important pre-requisite for effective maintenance and economical spare parts stocking. Standardization should conform to government guidelines and have commercial dealer back-up. Coordination between government purchases and donations of bilaterial and international assistance are also required.

Conclusions and recommendations of the meeting concerning transport operation and control included the following:

- Proper procedures for the utilization of transport, the supervision of drivers, the control of fuel and the control of other operational costs must be established to ensure that transport systems operate within available resources.

- Regular maintenance is the first and indispensable level of technical intervention to ensure proper functioning of motor vehicles, boats, and other transport equipment and to avoid costly breakdowns. No sophisticated tools are necessary for this level. However, facilities for carrying out preventive maintenance must provide coverage for the whole country. A mobile maintenance service has been mentioned as a possibility.

- The repair of vehicles requires more sophisticated workshop equipment in terms of facilities and workshop tools. Generally, one central repair facility is adequate for a country or a large region which has field workshops in outlying areas for preventive maintenance services.

- Training for each category of transport personnel and the development of suitable manuals are required.

Improved transport operation and control has been achieved in some countries. In the Bahamas, preventive maintenance programmes have been initiated in an effort to lengthen vehicle life and improve vehicle performance. The Equatoria Basic Health Services Project in the Sudan employs a maintenance engineer for equipment and transport servicing; he plans and supervises maintenance activities and conducts training programmes to expand the maintenance capabilities of local staff. Zimbabwe has established positions for transport officers who have overall responsibility for transport operation, maintenance and control.

SOME IMPORTANT CONCLUSIONS

- **Management development and training strategies that combine systems development with activity-based learning and staff development, are beginning to replace traditional management training with encouraging results.**

- **The development of a district planning process which defines objectives and sets targets is essential, particularly for newly decentralized systems. Operational workplans, specifying activities and responsibilities of teams and individual workers and developed in a participatory process, greatly enhance the morale and commitment of staff.**

- **Problem-oriented action research has emerged as a viable method for ensuring the participation of district managers and members of district health teams in seeking ways to improve the existing health system.**

- **The development of district-oriented health information systems has been identified as a priority need in an increasing number of countries. Efforts to train and support district staff in the production and use of health information appear to be most effective when they are part of general health management development strategies.**

- **Where health research groups or units have been established within ministries of health, or where action research has been explicitly adopted as a strategy for development, the result has been systematic analysis of problems, intensive exploration of opportunities and a marked willingness to learn through trial and error.**

- **The traditional barrier between hospitals and Primary Health Care activities has not been surmounted widely. Although some non-governmental hospitals have developed highly effective community outreach strategies, these have not been adopted on a wider scale.**

- **Special programmes, such as the Expanded Programme of Immunization, have largely succeeded in making repair and maintenance of equipment an integral part of their efforts. But general orientation of staff toward preventive maintenance of equipment and transport has not yet become a standard feature of district health management.**

Part B
5. Financing and Resource Allocation

Financing and resource allocation are part of planning and management. However, they are addressed separately to denote their key role in developing and sustaining health services, and to draw attention to the need for the district to take an active role in resource allocation decisions, in reviewing sources of financing and in the development of useful financial information systems.

In recent years, questions of cost and financing of health services have received much attention in many countries and international organizations, including WHO. New strategies have concentrated on cost recovery schemes at all levels but little progress has been made in improving information systems, monitoring resource use and changing the prevailing pattern of resource allocation.

SOME KEY PROBLEMS

- **Financial management and information systems are generally inadequate.**
- **There are not enough resources available for the health sector.**
- **The resources that are available to the health sector are usually not equitably distributed, and not efficiently used.**

Strengthening Financial Planning and Management

Most health systems managers in districts have little or no knowledge of financial management or health economics, partly because of the way they have been trained but mainly because of the separation of financial questions from their every-day decision making. This is a source of weakness in obtaining and managing resources.

In many countries, financial information is not available to assess how much is being spent on what. In the absence of adequate information systems, special studies may be conducted to assess costs and effectiveness of specific interventions and programmes.

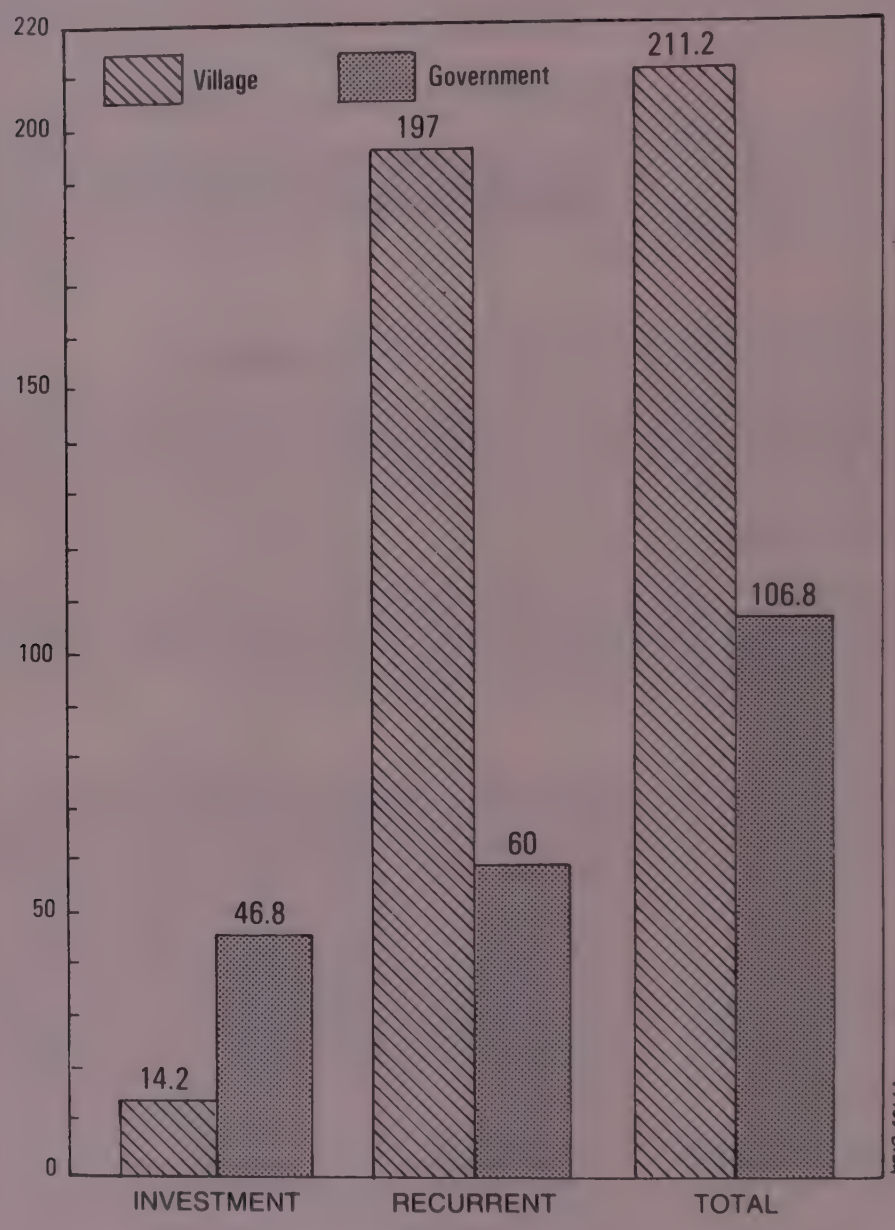
COST AND EFFECTIVENESS
THE TOMBALI DISTRICT PROJECT IN GUINEA BISSAU

In a study of the cost and the effectiveness of the Tombali project in Guinea Bissau, the investigators concluded that, contrary to common assumptions, Primary Health Care was quite costly both to the community and the government. At the same time, the project was found to be effective in achieving its major objective of making the district's villages self reliant in Primary Health Care.

In 1983, the per capita government expenditure on health services was US $ 2 (74 pesos) for the rural population. For the project, the recurrent and investment costs to the government alone use up more than this sum. Yet, these are just the costs for primary health care alone covering hygienic deliveries, treatment of six symptoms and some preventive work, excluding the costs of running the health centres and hospitals. Also, these figures already take account of substantial savings in investment cost which were effected when the project changed from village-based to more centralized training.

The government, with assistance from foreign donors, bears most of the investment costs (77%). But the benefits of investment expenditure are expected to last for no more than five years. This is a considerably shorter time span than is generally envisaged for investment expenditure; it is based on the argument that the benefits of a comparatively short training programme for non-literates will not endure beyond five years without substantial retraining.

Figure 2
Tombali District Project
Annual Investment and Recurrent Cost per Capita
(in pesos; 1983 prices; 37 pesos = 1 US $)



Government's contribution to recurrent costs consists of salaries, which are mostly accounted for by supervision of the VHWs and TBAs, by refresher courses, and by central administration. These week-long refresher courses are seen as vital to upholding and raising the standards of the VHWs work. Although the government does not pay a salary to the VHWs and TBAs, it must continue to support their work through training and supervision costs. Annual recurrent expenditure by the government amounts to about 25% of the government financed investment cost.

The villagers themselves directly contribute 66% of the total annual costs of their VHWs. This mobilization of local resources was only possible once the villagers were convinced that the government's commitment to the project was real. Also, they were not borne in the form of cash but rather in the provision of building materials and labour.

The recurrent cost contributions at village level amount to 77%. In most community-based health programmes, the major recurrent costs are usually for drugs and for the remuneration of the VHWs. In Tombali, the remuneration of VHWs was rather ingeniously avoided by training a large number of volunteer workers. Drugs were paid for collectively by the villagers. The government and the donors contributed the required foreign exchange and organized bulk purchases.

To a large extent, the details of the government/village contract about meeting these recurrent costs determine the long-term success of failure of primary health care schemes.

Source: Chabot, J. and Waddington, C., Primary Health Care is not Cheap: A Case Study from Guinea Bissau, 1987.
Waddington, C., Personal Communication.

Health managers should be able to exercise effective control over spending. They cannot do so without easy access to information on their budget and cash balances. In centralized systems it is the Ministry of Health which often does not effectively communicate this information, and in decentralized systems, the district treasury usually does not provide regular reliable statements of the health account.

In most countries and districts, sources of funding are varied and seldom well coordinated. Flow of funds profiles are often not available. To avoid fragmentation and duplication in the use of scarce resources, improved information on actual and potential sources of financing coupled with firm direction of available resources to priority activities and programmes are required.

District health management teams need to develop operational budgets which correspond more closely to their programme's objectives and activities. They need to obtain information that will provide a sound basis for reviewing costs of different activities, such as the cost of running a workshop, or of seeing one patient at a health centre.

The development of simple cost accounting procedures, as a first step towards programme budgeting, and the training of the district team in the use of such information, are initial stages in cost-conscious management.

PROGRAMME BUDGETING IN JAMAICA

Programme budgeting has recently been introduced into the Jamaican health system. For the first time, this allows PHC managers to relate expenditure to selected indicators of health achievements. Replacing the previous line-item budget which showed wages, travel costs, supplies, etc. for all activities together, the new format provides for five PHC programme areas or cost centres: MCH services, communicable disease control, environmental health, curative services and administration.

Sources of funds for each of these areas are shown separately, e.g. foreign assistance, donations and government finance. This system is expected to assist in setting realistic targets and in assessing performance. It provides a good example of how information on epidemiology and health services utilization may be combined with expenditure data in an integrated management information system.

Source: Campbell-Forrester, S.A., The Strengthening of District Health Systems. Primary Health Care in Jamaica, West Indies, 1987.

Making Better Use of Existing Resources

There is general concern in all countries that the available health resources are not being used most effectively or efficiently. An important share of health resources are wasted because of poor management practices and use of inappropriate technologies. Under-utilization of manpower is a major cause of waste. In situations where salaries consume 80% or more of recurrent funds, health workers can often be found sitting idly in health facilities, without drugs and supplies, without transport, without support and supervision. Another cause of waste is the deterioration of resources due to lack of maintenance and repair.

During the WHO Technical Discussions in Geneva in May 1987, participants in the working group on the use of resources identified strategies for improving the cost-effectiveness of services, including suggestions to reduce emphasis on special services and programmes which often aggravate deficiencies at intermediate levels and result in failure to focus resources effectively on local health problems; regularly to evaluate the cost-effectiveness of the public services; and to use practical health systems research to generate information about health care resources, costs, activities and quality of care for immediate use in planning and problem-solving.

Based on detailed studies, a number of countries have already begun to implement cost containment strategies and cost savings plans.

COST SAVINGS AND COST CONTAINMENT

Malawi
In its 1986 - 1995 National Health Plan, Malawi introduces cost savings strategies. The plan states that "the focus of this effort must be those areas which absorb large portions of the annual budget. Two thirds of total expenditure was incurred by the 24 government hospitals, with expenditure on non-curative non-institution based activities very low. It has been clear for some time that savings can be effected in the hospitals without detriment to the 'output' of these institutions, especially in the areas concerned with food, overheads, drugs, vehicle expenditure and hospital supplies."

Subsequently, a cost savings implementation plan was drawn up for Malawi's largest hospital. As a first step, savings amounting to 43% for

food alone have already been effected. In the meantime, based on detailed analysis of the hospitals expenditure pattern over the last three years, investigations are made into the high level of expenditure for water, fuel and transport.

Sources: Five Year Development Plan Malawi 1986–1991.
WHO Travel Report, 1987.

Brazil
The recession beginning in 1981 prompted Brazilian authorities to contain health costs. The social security medical system closed several underused hospitals for tuberculosis and psychiatric care. Contracts with private hospitals were rewritten so that payments are now made on the basis of diagnostically-related groups. The system expanded its payments to state and local governments that provide basic health care. Costs had been growing by 22 percent a year in the 1970s but fell in the early 1980s and are projected to grow by no more than 6 percent a year through 1989. Cost containment has been achieved with no evidence of declining quality; more effective incentives have prompted providers to eliminate waste and unnecessary services.

Source: Financing Health Services in Developing Countries — An Agenda for Reform, World Bank, 1987.

Reviewing Resource Allocation Options and Decisions

Despite stated commitment to Primary Health Care, the prevailing pattern of resource allocation in many countries still reveals a bias towards services in urban areas; secondary and tertiary services; curative rather than preventive services. A recent international study indicates that 70 to 87% of total health expenditures go to curative care for personal services and purchases of medicines. Only 10 to 20% go to patient-related preventive services, such as MCH clinics, and 3 to 10% to disease control programmes, sanitation, health education, and other public health services. This is both economically inefficient and socially inequitable. Table 1 below shows the spending pattern and the cost of various health services in a large sample of countries.

Table 1
Spending for and Cost of Various Health Services

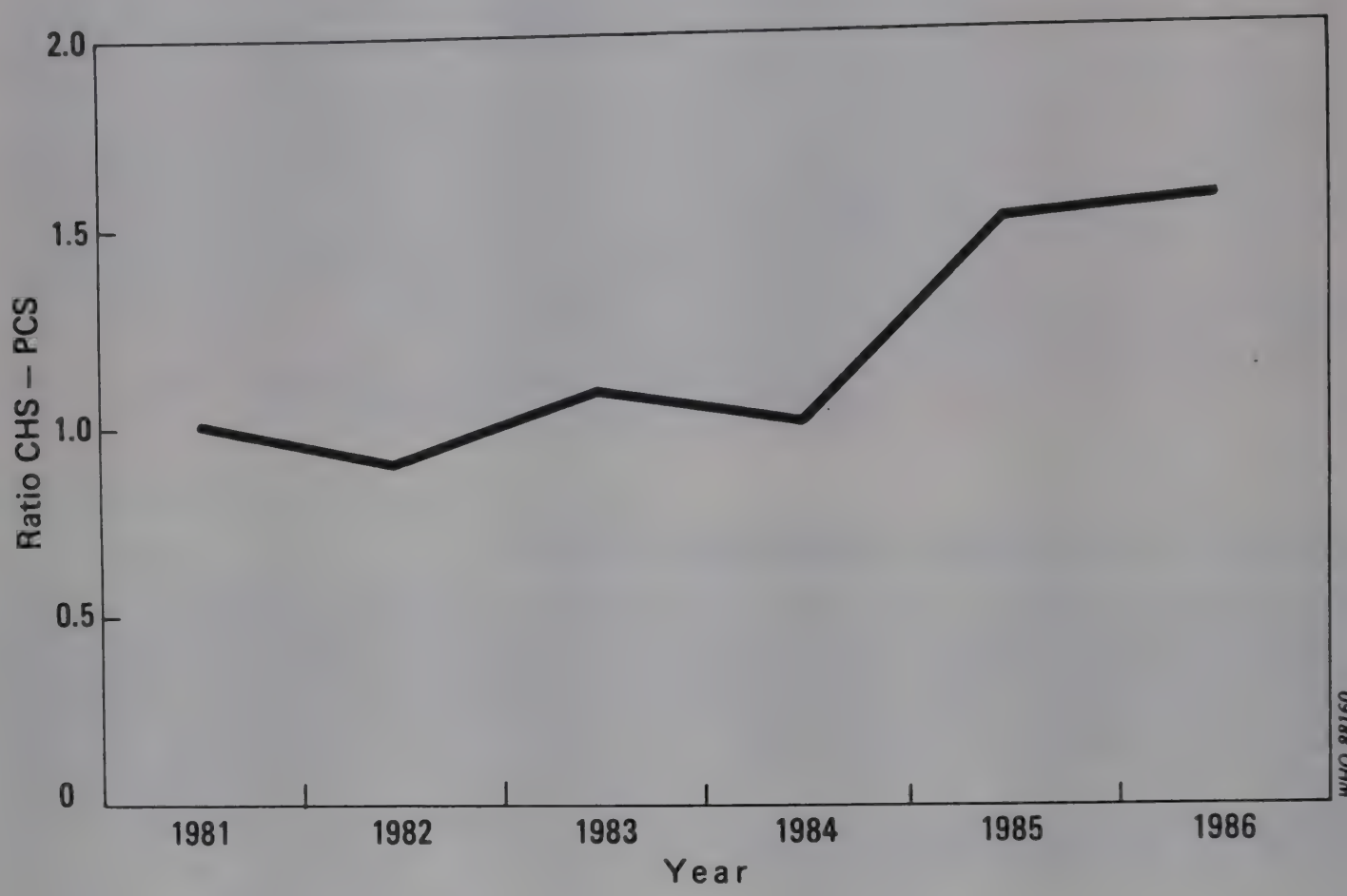
Services	Percentage of total expenditure on health	Approximate cost per additional life saved (U.S. dollars)
Direct services to patients		
Curative Treatment and care of patients through health facilities and independent providers (including traditional practitioners) Retail sale of medicines	70–85	High ($500–$5,000)
Preventive Maternal and child health care (for example, immunization, growth monitoring, family planning, promotion of better breastfeeding and weaning practices) Adult care (for example, hypertension screening, pap smears)	10–20	Medium ($100–$600)
Community services Vector control programs Educational and promotional programs on health and hygiene Monitoring of disease patterns	5–10	Low (less than $250)

Source: Financing Health Services in Developing Countries — An Agenda for Reform, World Bank, 1987.

A radical review of resource allocation priorities within the health sector is often required. This should include an assessment of where these decisions are made, e.g. at central or at district level; and what information provides the basis for allocation.

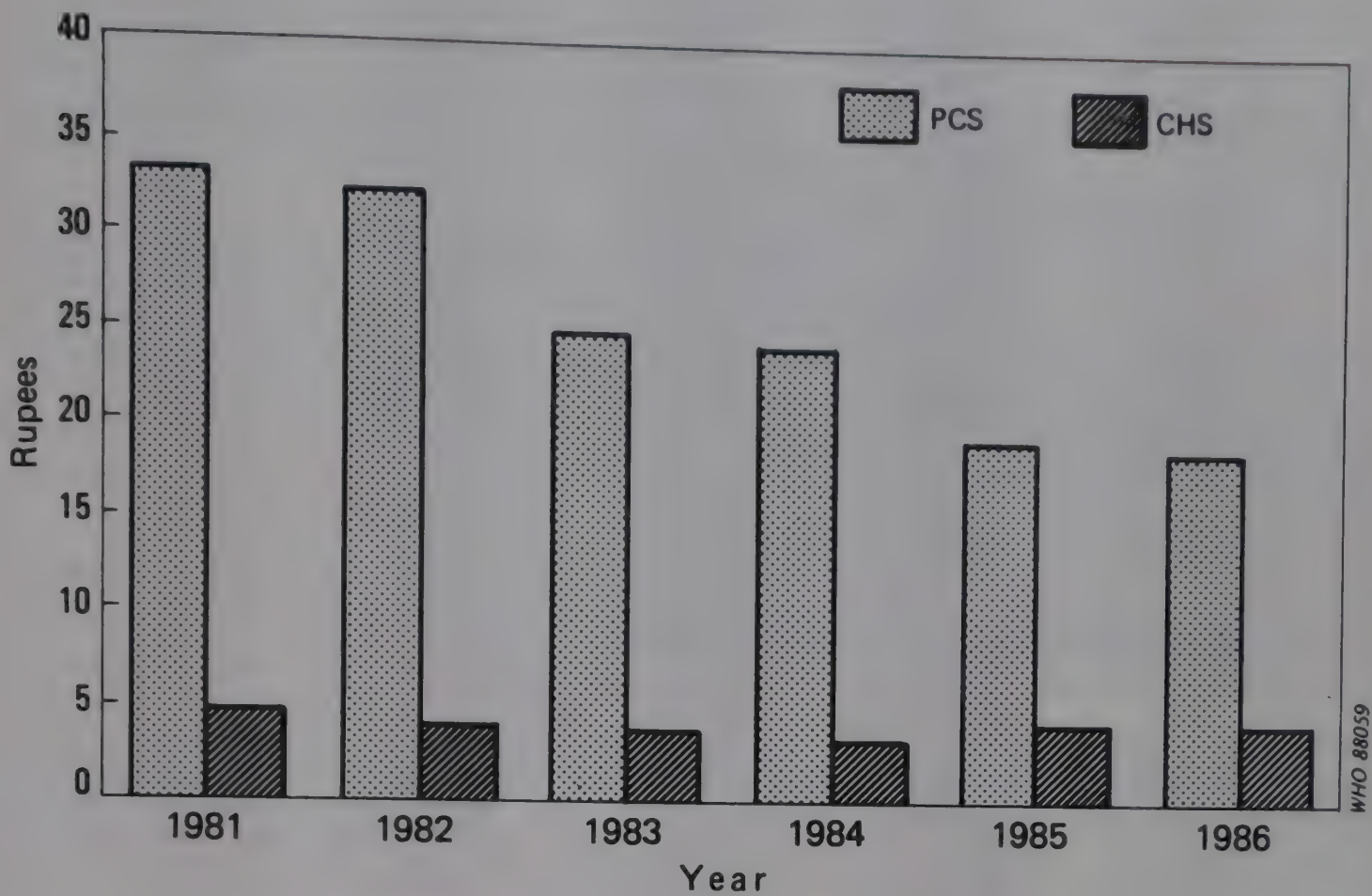
In Gampaha District in Sri Lanka, the ratio between community health services (CHS) and personal curative services (PCS) changed from 100:100 in 1981 to 100:62 in 1986, as shown in Figure 3.

Figure 3
Ratio between Community Health Services and Personal Curative Services, 1981 to 1986



While total real per capita health spending decreased between 1981 and 1986, community health services received a steadily increasing share of the available resources. The Sri Lankan expenditure pattern is the result of a firm and unambiguous Primary Health Care policy that has been translated into financial plans and actions.

Figure 4
Gampaha District, Sri Lanka: Trends in Real per Capita Spending



Source: Attanayake, N. and de Silva, U.H.S., Economic Analysis of Health Sector Resource Flows in Gampaha District of Sri Lanka, 1987.

Broadening the Resource Base

In many countries, health services are primarily financed from general public revenues. The size of the health budget depends on the country's level of income and its development philosophy. The traditional alternative for ministries of health has been to attempt to obtain a greater share of resources from the national budget by arguing the case for health in a more convincing way. However, in many instances, government revenues have been declining, and populations rapidly increasing, so that even an increased share of the available government resources for the health sector may mean a decrease in government health expenditure per capita. Lack of ability to document resource flows has not strengthened the MOH case.

The actual and potential contribution of local government has been underestimated; as have private, non-governmental and traditional health providers who often deliver the bulk of services in a country, financed directly largely by the charges to consumer. Thus, all health care providers need to be taken into consideration, when exploring additional and alternative sources of finance.

In addition to central and local government funding, a number of options for financing services are now being widely considered.

User charges for health services are being introduced in many countries. Schemes differ widely in terms of level and type of charges and exemptions. The impact of user charges is not yet sufficiently known. Some recent studies indicate, however, that utilization of services can be greatly affected. Careful monitoring of the effect of user charges is, therefore, needed.

USER CHARGES AND UTILIZATION IN GHANA

In mid-1985, the Government of Ghana substantially increased charges for curative services. The primary aim of the increase was to generate income. This was to be done as equitably as possible and with allowances for free medical care to persons and families who could not afford to pay. A certain percentage of the income was to be returned to the health facility where the fees were collected.

In 1988, a study was carried out in the district of Ashanti-Akim to assess the impact of these charges on utilization of health services. In urban areas, utilization returned to its pre-charge levels after an initial drop in reaction to the higher charges. However, utilization has fallen and remained substantially lower in rural areas (Figures 5 and 6).

Figure 5
Utilization: Rural Health Centres

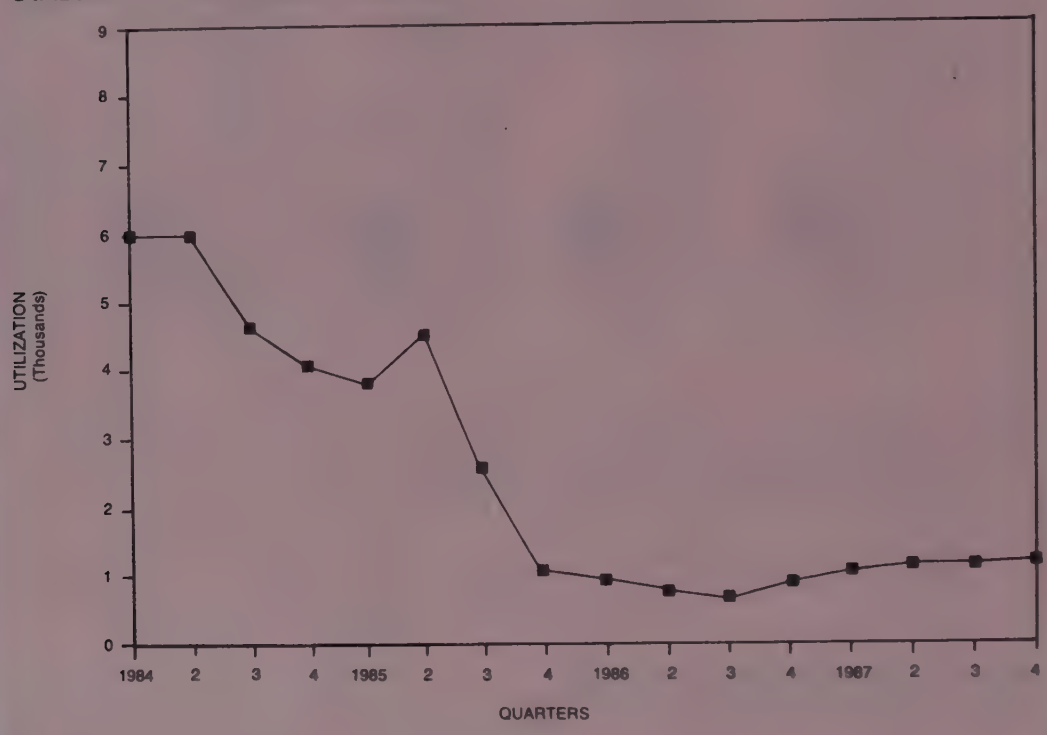
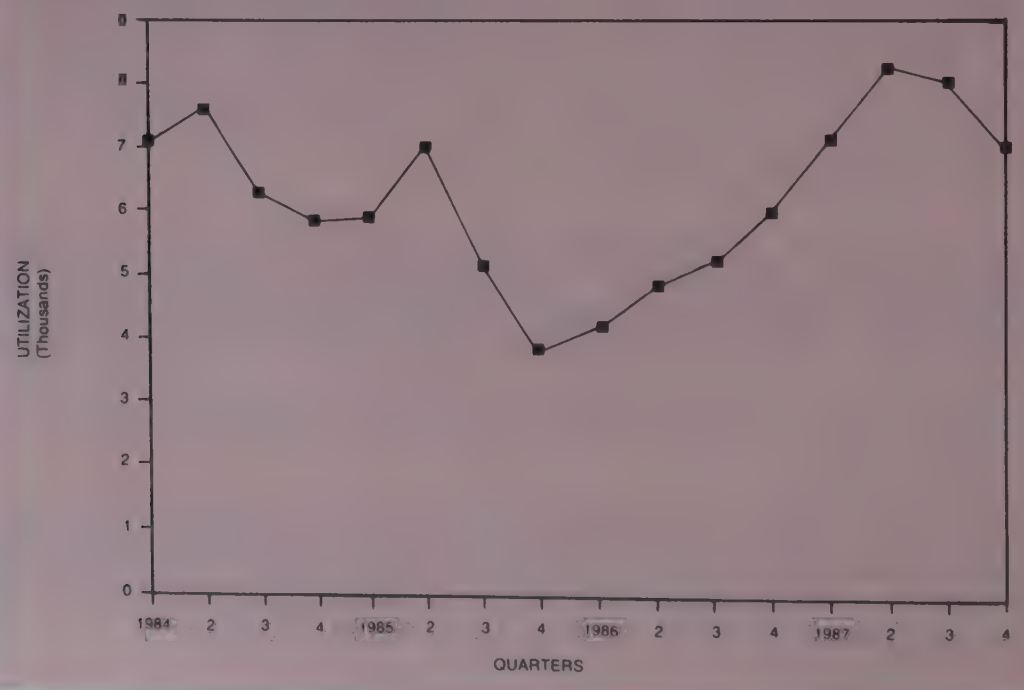


Figure 6
Utilization: Urban Health Centres



In many ways, user charges have been a success in Ghana. The aim of recovering 15% of the total costs has been realized within 3 years. Health facilities can themselves spend 25% of the revenue they earn. This is popular with health workers because it means that small items can be bought locally without the delays which had occurred previously. But the Ashanti-Akim study also suggests that apart from improvements in drug supplies, there has been no significant positive change in staff attitudes, waiting times, and other qualitative aspects of care, and that the fee scheme has not served as an incentive for health providers to become more responsive to patients' needs.

There appear to be some intrinsic disadvantages with the present system related to affordability and equity. The evidence from Ashanti-Akim shows that some people are no longer able to afford the services. Even where 'willingness and ability' to pay is demonstrated by utilization of services, family economies have been badly affected when a relative falls seriously ill. The rural population has clearly suffered a disproportionate drop in utilization since the introduction of user charges.

Source: Waddington, C. and Enyimayew, K.A. The impact of user charges in Ghana: a case study from Ashanti-Akim, 1988.

Community financing schemes are another option for funding health costs. A variety of insurance schemes can be used to help finance health services rendered to individuals and families and to share risks within the community.

RURAL RISK COVERAGE: THAILAND'S HEALTH CARD SYSTEM

The Health Card Project in Chiang Mai province is the pilot phase of a comprehensive Thai national health insurance system, the Health Card Programme (HCP). The HCP started in 1983 as a means of realizing the goals of Primary Health Care: it was thought that since the health services would be partly financed by the consumers, the latter would have some degree of control over the services. As the HCP required adherence to strict referral processes, it was expected to promote disciplined and economic utilization of the health services. Cost recovery was not a prime concern for the Ministry of Public Health in the early period of the HCP. In practice, the emphasis has shifted: the pilot project in Chiang Mai province aims to recover 100% of direct treatment costs (30% of total costs).

Possessing a health card, which is valid for one year, entitles its holder to free preventive care and to free treatment for a specified number of illnesses. The ceiling for free treatment is set at 2,000 Baht per illness. The card holder is promised preferential access to quick services via a 'green channel' at referral centres, provided he has a referral note from the health centre or the village health volunteer. Funds from card sales are used for reimbursing service providers, community development and loans to card holders. Unused cards are renewed at full price.

Early evaluation reports suggested 'uniform enthusiasm' for the health card among most card holders. However, recent evidence from Chiang Mai province is less optimistic. A case study from Mae Na sub-district

concluded that the demand for the health card would decline in that sub-district in 1989. Several factors were identified as limiting the growth of the HCP:

- Consumers' dissatisfaction with the quality of personal care rendered by the MOPH's facilities. There were complaints about poor staff attitudes and long waiting periods.
- Several householders could not afford the health card. For some, this was due to absolute poverty. It might also be because the sales period was not planned to coincide with the period of highest income — the immediate post-harvest season.
- The lack of subsidised rates for renewing unused cards was a disincentive to the renewal of unused cards.

The Ministry of Public Health is now considering the implications of these findings. It is expected that strategies to alleviate the problems that have arisen will be developed.

Source: Adeyi, O. O: Requiem for the health card? Sustaining the demand for rural health insurance in Thailand: A case study from Chiang Mai province, 1988.
Financing Health Services in Developing Countries — An Agenda for Reform, World Bank, 1987.
Adeyi, O.O., Personal Communication.

SOME IMPORTANT CONCLUSIONS

- **Primary Health Care policies become a reality only if and when they are translated into budget allocations and reflected in actual expenditures.**

- **Where performance budgeting systems are used, it has been possible to combine epidemiological data, information on utilization and expenditure data in an integrated management information system. This has improved target setting and regular performance review.**

- **Flow of funds profiles have been established in some countries resulting in better coordination of diverse financial inputs and increasing the confidence of donors with regard to resource utilization.**

- **Based on throrough studies of expenditure patterns, cost savings strategies can be readily devised. In some countries, such strategies have achieved savings of 50% and more.**

- **A wide variety of financing and cost recovery schemes have been implemented around the world. Careful assessment of their effect on utilization patterns and health status is required.**

- **In countries where a large proportion of services are provided by non-governmental organizations, subsidies are a useful way of supporting these efforts while ensuring that their orientation is congruent with government health policy.**

Part B
6. Intersectoral Action

Intersectoral action in the district concerns the promotion and coordination of different sectors' contributions to health and improvement of the quality of life. It covers environmental changes, such as clean water, improved sanitation and housing, better food supplies and the raising of income and educational levels as means of improving health. Achieving equity and reaching vulnerable groups are critical aspects of planning that require intersectoral perspectives and collaboration.

It has been widely recognized that sustained improvement in the health status of populations can only be achieved through the combined impact of a wide range of socioeconomic developments. Health is not the concern of the health sector alone but also requires the action of other social and economic sectors. There is widespread support for the idea of intersectoral action. However, practicable solutions that have been successfully implemented are only gradually emerging.

SOME KEY PROBLEMS

- **District development committees provide an important opportunity for district medical officers to inform and convince their colleagues from other sectors of the objectives of Primary Health Care, and to promote activities in other sectors that will benefit health. This opportunity is rarely adequately utilized.**
- **Sectoral priorities and administrative structures often prevent pooling and sharing of resources between sectors.**
- **Insufficient attention is paid to identifying vulnerable groups at high risk of death and disease, and to developing and implementing intersectoral strategies for reaching them.**
- **Even where vulnerable groups have been identified, little has been done to implement systematic surveillance and intervention programmes.**

Incorporating Health Improvements in Social Development

Given the multisectoral character of health development, the coordination of health-related activities of the different sectors has been proclaimed as a priority concern. But in most countries, health planning at the centre and in the district has remained a more or less self contained exercise within the health sector, carried out principally by health professionals, in relative isolation from other development sectors. This isolation is reinforced by the continued perception of health as determined mainly by medical services. However, in some countries innovative approaches to improving health as part of quality of life have been developed.

THAILAND: THE BASIC MINIMUM NEEDS STRATEGY

Recognizing the inadequacy of past approaches, the National and Social Development Board, in 1980, initiated a new and innovative social development project with the aim of creating common long-term social development goals of which Primary Health Care was an integral part. The project arranged brain-storming sessions of experts from the four major ministries (Agriculture and Cooperatives, Education, Interior and Public Health) and other agencies concerned with social development to formulate long term desired characteristics of Thai society and people. The concept of Basic Minimum Needs at village level was developed and used as a guide for equitable allocation of limited resources and basic services to the people. The successful implementation of this approach

in real village situations in many areas of the country helped create acceptance among policymakers. Eventually, the Basic Minimum Needs approach was adopted as a national policy, and also taken as a basis to launch a nationwide Quality of Life Mass Campaign which is currently underway.

The following are the eight Basic Minimum Needs:

- Family members consume sufficient nutritious and safe food for their physical needs.
- Every family has appropriate shelter and environmental conditions.
- People have the opportunity to receive those basic social services which are necessary for maintaining life and occupation.
- People have security in their lives and possessions.
- People have efficient production and procurement of food.
- Families are able to plan the spacing and number of children.
- People participate in developing their own and their community's way of life.
- People have spiritual development.

The programme operates by collecting information according to 32 BMN indicators at village and household level and compares this with established standards. Gaps are identified. The villagers, through various committees, discuss possible solutions and determine the priority of the various problems. It is through this process that people are motivated to participate in the various activities and realize their own potential of solving the problems.

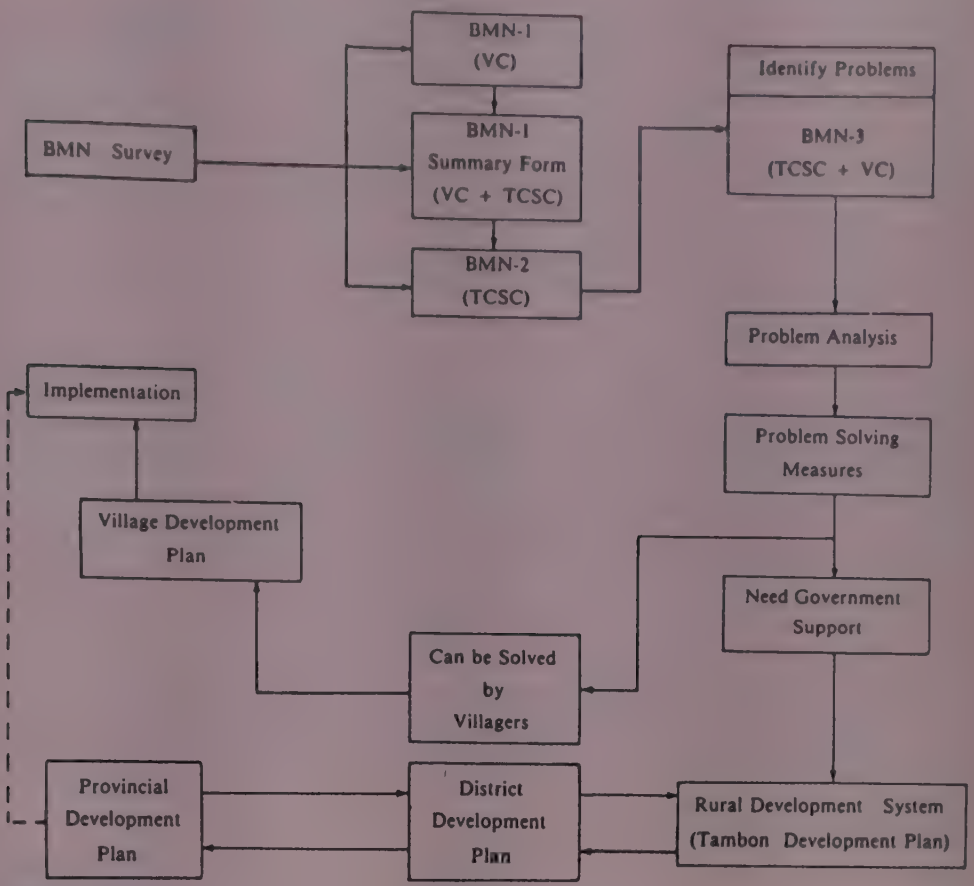
The process starts when the village committee in collaboration with the tambon (sub-district) council supporting committee conducts surveys of every household and collects information on the general village situation. The tambon and district councils then compile the information and compare results with established standards. Where village BMN indicators do not meet the aspired standard, the village committee and the tambon council supporting committee identify problems together.

Next, the tambon council supporting committee and village committee call for meetings with the villagers to determine the causes of and solutions to each problem. The solutions are then grouped into three, namely, solutions to be undertaken by government (1), solutions to be undertaken jointly by the government and the villagers (2), and solutions that can be undertaken by the villagers without external assistance (3). The tambon council supporting committee and the village committee formulate plans and prepare projects for group 1 and 2 and submit them to the tambon council for budgetary appropriation. Resources in these cases are mostly obtained either directly from local sources such as local taxes, or from central government transfer.

For group 3 activities, the village committee and the villagers determine through consultations what type of activities to be undertaken and within what time frame. Solutions are based on the consensus concerning priority of problems, opportunity and potential of the village.

Each year, a survey is conducted again, the results are compared with the previous ones, and continuing as well as new activities are agreed upon.

Figure 7
Planning for Basic Minimum Needs



Sources: Boonyoen, D., Health Aspects of Development Planning at Village Level, 1987.
Intersectoral Action in Health Development in Thailand, Colloquium on Leadership Development, 1986.
Tansakul, O., Methodologies for Identifying Vulnerable Groups: Quality of Life Indicators, 1987.

Targeting Vulnerable Groups

Intersectoral action is also required to reach out into all homes and work places to identify systematically those at highest risk, to provide continuing care and to eliminate factors contributing to ill health. While the health sector has generally recognized the importance of groups at risk, it has seldom approached the health problems through a systematic identification of vulnerable population groups and the conditions of risks in which they live. Such an approach immediately confronts the health sector with the health risks that originate in other sectors and the health-related concerns of those sectors. But even where vulnerable groups have been identified, little has been done to implement systematic surveillance and intervention programmes.

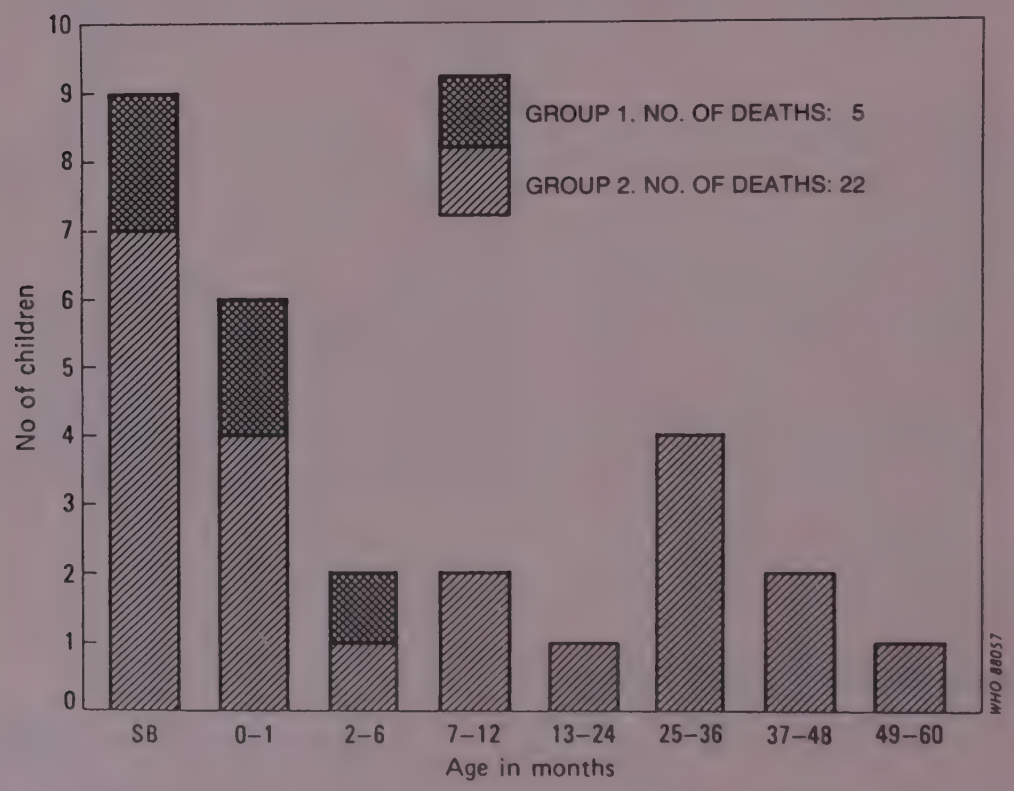
It is possible, however, to start by carrying out studies to identify the characteristics of households at risk that can serve to orient the interventions of government and community health workers to those pockets of high vulnerability.

ACTION RESEARCH TO DEVELOP RISK STRATEGIES

Machakos District Kenya

The Kibwezi Rural Health Project in Machakos is a community-based health project supported from a large rural health centre, operated by a regional non-governmental organization and the Ministry of Health. In 1985 and 1986, surveys were carried out in collaboration with community health workers, health centre staff and researchers from Nairobi, with the objective of assessing levels of stress and vulnerability among the target population. The first of these surveys used eight selected variables representing economic status, access to water, child nutritional status and disability, to construct a composite indicator of vulnerability, the Multiple Stress Index. The second survey used an additional set of indicators, developed with community health workers by systematically exploring their perceptions of factors related to health risk. It then related the risk indicators of the community health workers and those of the first survey to morbidity and mortality data. The results showed a clear separation of the two groups of households, characterized as high risk and low risk respectively, suggesting that the selected risk factors are valid predictors of health outcomes.

Figure 8
Child deaths by Low Risk(1) and High Risk(2) Groups in Kibwezi, Machakos



Using the emerging method for identifying high risk households, the community health workers were in a position to establish an early warning system for households at risk and to develop targeted surveillance and intervention programmes.

Matale District Sri Lanka

The main purpose of a health study carried out in Matale District in Sri Lanka by the Marga Institute was to identify the links between the existing patterns of morbidity and the socio-economic and physical environment of the households. In uncovering these linkages, the study expected to indicate how other sectors interact closely with the health sector to affect the health outcome. The researchers examined these linkages in four clusters, covering resource flow, occupation and employment; food, nutrition and consumption patterns; water, sanitation and housing; and education, knowledge and behaviour patterns. They also studied the effect of seasonal variations on the incidence of ill health.

The study findings led to the design of possible courses of intersectoral action aimed at identified vulnerable groups within specific locations, taking into account seasonal factors. Proposed programme elements include interventions such as management of farm budgets to minimize seasonal troughs; rural credit systems; food stamp schemes; upgrading of temporary and semi-permanent housing; and improvement of access roads.

Sources: Gunatilleke, G. ed., Seasonality and Health, 1987.
Ferguson, A. et al, Kibwezi Integrated Survey, 1985.
Ferguson, A. et al, Kibwezi Health Risk Study, 1986.

District Management Committees

District management committees, comprising only the heads of all district departments, while reporting to the usually much larger district development committee (DDC) can provide an effective mechanism for sharing information and resources and, eventually, for the development of joint action. In many cases, DDCs are an excellent forum for discussing district policy and broad plans, for informing colleagues from other sectors of the objectives of Primary Health Care, and for promoting activities in other sectors that will benefit health. But they are usually too large and do not meet frequently enough to be involved in operational planning. The district management committee is the executive group that fills this gap. It is linked to both the DDC and a network of local development committees operating from the village level upwards.

The main function of a district management or executive committee is the development of annual district plans that include targets and operational budgets. In some instances, two-year rolling plans are designed to allow strategic medium-term planning while explicitly recognizing the need to review and adapt the second year of these plans on the basis of experience gained during the first. Another function of this committee is to review quarterly progress reports and to adjust targets accordingly. Also, results from surveys and studies in the district are shared. District management or executive committee meetings thus provide the basis and the opportunity for examining the health aspects of other sectors and advocating health promotive strategies.

Where Primary Health Care has been adopted as a high priority among development goals, more specialized district health committees are a very effective mechanism for promoting and coordinating intersectoral action for health.

ZAMBIA: DISTRICT ACTION COMMITTEES FOR PHC

Following the second Primary Health Care Review in 1985, a national group with membership from the Ministries of Health, Agriculture, Labour and Social Services, as well as the National Food and Nutrition Commission, the Institute of African Studies and the Department of Community Medicine from the University of Zambia, was formed to support the implementation of a project for strengthening intersectoral action in a number of selected areas, starting in Mumbwa District in Central Province. The purpose of the project was twofold. Apart from developing and sustaining intersectoral initiatives in the district, it was to provide an opportunity for members of the national PHC committee and of the district committee to gain first hand experience in carrying out community diagnoses, to engage in a dialogue with community members, and to bring the national actors closer to the realities, the concerns and constraints of the district level.

In 1986, three days of orientation training were organized for the district PHC committee by the national action group reviewing PHC strategies for the district, the rationale and importance of intersectoral action in health development and the details of the project. The district committee which had also formed an action group to work with the national group, then identified three areas for initiating the project. Local committees were formed in these areas and the planning for community diagnoses proceeded. This included the development of a household questionnaire by national, district and local committee members. In early 1987, household surveys were conducted in the three selected locations. National participation was gradually decreased so that the final survey was mainly conducted by the district team. The data is now being analyzed and will be used for discussion and planning by the district with the local committees.

Source: WHO Travel Report, 1987.
Martin, J., Personal Communication.

SOME IMPORTANT CONCLUSIONS

- **Approaches to improving health as part of quality of life have been successfully implemented. The development of basic minimum needs standards has not only served as an instrument for fostering intersectoral action. It has also provided a sound basis for community involvement in planning and implementing strategies for improving quality of life.**

- **Action research has served as a useful tool for identifying vulnerable groups and for orienting intersectoral action toward these groups.**

- **In many countries, district management committees have proved to be a very effective mechanism for promoting and coordinating intersectoral action for health. The development of PHC plans, preceded by orientation seminars for key actors in the district, has often provided the impetus for joint action.**

Part B
7. Community Involvement

Community involvement addresses itself to the task of mobilization, putting in motion a widespread process of collective organization and involvement which leads to increased human and material resources at the local level being channeled into development efforts. It seeks to create support mechanisms for community involvement in health in order to establish the preconditions for full participation and to clear the way for the required changes. It is also concerned with community health workers and with other change agents in the community.

SOME KEY PROBLEMS

- **Prerequisites and conditions for community involvement are not present in most places.**
- **There are inherent contradictions between orientation and structure of most government health systems and conditions necessary for community participation. Insufficient attention is given to necessary policy and structural changes within health systems.**
- **District medical officers and their teams often do not appreciate the value of community participation and are not sufficiently motivated or skilled to facilitate and support community involvement.**
- **Methodologies for re-educating and re-orienting health staff towards community involvement have not been very effective. Although workers have been trained and can repeat the 'right' words, their basic attitudes remain unchanged.**

Support for Community Involvement in Health

It has become clear that community involvement for health cannot emerge and develop without the deliberate support of appropriate mechanisms at different levels. The evidence to date suggests that in those countries where community involvement for health has begun to develop, it has done so with the assistance of a range of support mechanisms. In the first instance, however, it is important to establish the preconditions for community involvement, that is, the factors that can favourably affect the necessary mechanisms.

During the 1985 Inter-Regional Meeting on Community Involvement for Health in Brioni, the following were identified as preconditions:

- political commitment to community involvement for health
- bureaucratic reorientation to community involvement for health
- development of self-management capabilities of local communities
- minimum basic health structure and coverage.

Once these preconditions are met, the most important support mechanisms for community involvement are

- effective decentralization
- network of local structures
- intersectoral coordination
- logistics support
- support from NGOs.

As can be seen, the preconditions and the support structures for community involvement are in many instances identical with those of district health systems as a whole. Community involvement depends critically on a well established and functioning district health system.

The Basic Concept

The concept of community involvement for health (CIH) in the formal sense dates from the mid 1970s. Since then its merits and the forms of change it would bring about have been widely argued in publications and at conferences. Since Alma Ata, community participation has often been proclaimed as the key to success in the implementation of Primary Health Care. CIH has been put forward as the antidote to a set of problems which have been plaguing the health sector:

- health strategies failed to encourage people to think or act for themselves and did not foster self-reliance;
- there was inadequate training at community level, therefore, services that were established could not be sustained by local knowledge and resources;
- there have been community contributions in terms of resources and manpower, but there was little active involvement in the design and implementation of projects and programmes
- the conflict between health-directed needs, as determined by the health service and the medical profession, and health-related needs, e.g. water, housing, as determined by local people themselves, often resulted in an incompatibility of desired approaches.

The concept of CIH has, therefore, been enthusiastically welcomed as the fundamental change in direction required to promote effective health development. CIH has become a message of widespread influence. In theory, at least, health authorities have given their support to CIH as a basic principle to be followed in health development.

And yet we have to accept that, given its relative newness as a strategy in health development, the theory of CIH is to date somewhat ahead of the practice. CIH as a fundamental principle of formal health service practice is still largely underdeveloped.

There is considerable confusion as to the practical meaning of community involvement. Community participation is interpreted in a variety of ways. Some see it as a means to improve the efficiency of their service delivery system, a managerial technique intended to benefit both provider and consumer. In this case, the results of participation in terms of the predetermined targets are considered more important than the act of participation. An alternative view is to see participation as an end in itself. The emphasis here is on the process in which confidence and solidarity between people are built up. In this context, participation is a dynamic, unquantifiable and essentially unpredictable element. It will extend beyond the project into a permanent dynamic involvement. But the examples of such genuine community involvement are few.

Source: Oakley, P., Community Involvement for Health Development — an examination of critical issues (in press).

Political Mobilization

In countries, where community involvement is based on mass mobilization, its initiation and development tends to be anchored in political structures committed to upholding the rights of workers and peasants.

PEOPLE'S PARTICIPATION IN YUGOSLAVIA AND ETHIOPIA

In **Yugoslavia**, community participation is seen in two ways. One is the mobilization of people for direct participation in implementing a community-based programme, through different forms of self-care, by financial support, in-kind contributions, or with their own work; in this case they are self-providers of services. The other is when users participate in the managerial process, thus taking over the role of decision-makers; in this way they are most directly included in the process of social control.

It is this second form of participation which has been developed in Yugoslavia in line with a more general strategy of promoting self management in all public services and social activities. So called 'self

managing communities of interest' are constitutionally based. Their assemblies are formed by the delegates of health users (workers and citizens) and of health providers. Within these communities, formed at all levels, health needs are identified and programmes are developed and managed based on the principle of solidarity. A free exchange of labour takes place between the users and the providers of health care services.

In **Ethiopia**, the concept of greater peasant participation emerged as a cornerstone of the revolutionary process. Peasant participation was presented as evolutionary and was governed by three basic principles: voluntary participation, mutual benefits and the strict application of democratic centralism. In this process of developing and institutionalizing local participation, the Provisional Military Administrative Council used two basic means:

- the Zemacha: the mobilization of secondary school and university students to spread out throughout the country, make contact with the peasant communities and prepare the ground for participation;

- peasant associations: which were formed as the lowest administrative unit of the State, and were to agitate and mobilize the people to participate in political and economic activities. Since this first impact, the emphasis has been upon agricultural collectivisation and the developing of cooperatives as the basis for continued peasant involvement.

Sources: Primary Health Care in Yugoslavia, 1986.
Oakley, P., Community Involvement for Health Development — an examination of critical issues (in press).

Result-oriented Community Participation

Many important health promoting, disease preventing and curative activities are only feasible as part of individual, family and community responsibilities. Fostering community participation in these activities is critical to achieving desired health results. As a result, many of these efforts are characterized by a vision of participation as a means to achieve established objectives rather than as a process that is created and moulded by the participants themselves. In the absence of mechanisms for linking up with mass mobilization for popular participation that permeates sectoral boundaries, these result-oriented strategies will continue to be the main option for the health sector itself to achieve participation.

COMMUNITY-BASED HEALTH CARE IN KENYA

Community-based health care (CBHC) projects of very different types have been operating in Kenya for more than ten years, mainly by non-governmental organizations. The development of CBHC is influenced by a conceptual conflict: balancing the need to stimulate households and local communities to determine their own health care needs and to initiate interventions, on their own terms, to meet these needs; and the government's wish to extend its health services down to sub-location and village level, at modest costs and under control of MOH health professionals. The actual degree and quality of local community involvement is therefore crucial when reviewing so called CBHC projects. Despite a rich experiential base of CBHC initiated by NGOs, there is little evidence that these experiences have influenced government policy on community involvement in health.

A critical review of CBHC experiences was carried out in 1984 and arrived at the following conclusions:

- Initiation of CBHC, including sensitization of villages and village leaders, is a time-consuming and unpredictable process; several months, sometimes 1–2 years, may be required before an understanding and appropriate support are established.

- Existing health service institutions of curative orientation tend to become models for village leaders who wish to promote some sort of CBHC in their community; unless reoriented themselves, existing health centre personnel may not be the most suitable initiators and motivators of CBHC.

- Church-related NGOs are often able to use their congregational infrastructure in support of CBHC which makes them difficult to compare with government-initiated programmes.

- Willingness to work as part-time volunteer in a village varies from one area to another; monetary compensation is expected in cash economy areas and may require special income-generating schemes which take time to establish.

- Drugs in the hands of CHWs make it difficult for them to maintain a promotive/preventive emphasis in their work; it still may be necessary to accept a wish of the local community to that effect, particularly if there is no alternative way of making basic drugs available.

- Continuing supervisory support of CHWs is important, and health institutions given supervisory responsibility must be provided with adequate resources to do the job.

- The level of CBHC activities may vary considerably between seasons and between years, depending on competing responsibilities and tasks of the CHWs; neither this nor a certain drop-out rate should be considered signs of failure.

Sources: Nordberg, E., and Eriksson, C.G., Community-Based Health Care in Kenya, 1984.
Nordberg, E. Health, Health Care and Family Planning in Kenya, 1986

Where Top Down and Bottom Up Meet

A number of successful efforts have been launched in creating community awareness of Primary Health Care and in strengthening the interface between formal and informal, community-based health services.

Community health workers and formal and informal leaders are frequently involved in informing and preparing the community for the visit of a team of health workers to a community health post or for an under-the-tree clinic. There is a wide range of experiences for sharing responsibility for organization and management of these visits between the formal health sector and the community.

THE INTEGRATED SERVICE POST IN INDONESIA

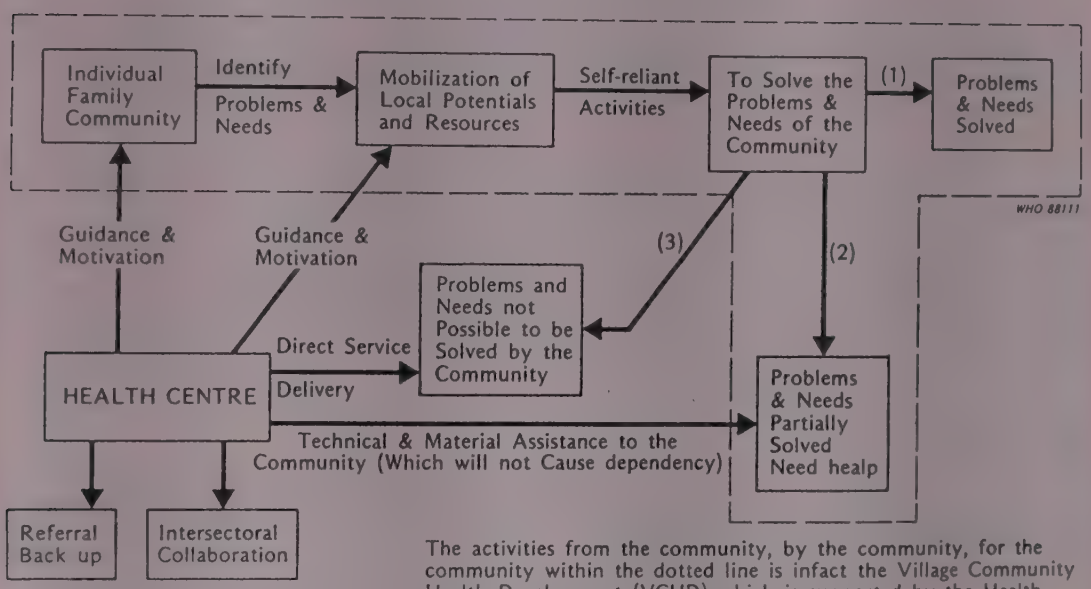
In Indonesia, community health services are offered from integrated service posts called posyandu. This is where volunteer cadres from the community and formal health service staff from health centres meet for one day per month to offer integrated family health services.

The posyandu or integrated service post is a forum for communication, transfer of technology and delivery of health services by and for the community. It aims to integrate

- intersectoral development programmes
- intrasectoral health programmes
- professional and traditional services.

The health services provided from the posyandu cover maternal and child health; family planning; immunization; nutrition improvement; and diarrhoeal disease control.

Figure 9
The Mechanism of Community Participation in Indonesia



The activities from the community, by the community, for the community within the dotted line is infact the Village Community Health Development (VCHD) which is supported by the Health centre in collaboration with related sectors.

The development and operation of the posyandu is organized and supported by the Women's Family Welfare Movement (PKK). The PKK is not an organization with a registered membership. It is a voluntary movement, oriented to the development of communities both in rural and urban areas and promoting better welfare and a decent standard of living. The movements' target groups are family units, with the mother as the focal point. PKK is part of the programme of the Community Resilience League which is the vehicle for community participation in the execution of rural development policies and helps plan and implement local development activities.

PKK and the Community Resilience League have boards at all levels of local government and at the national level as well. Throughout the country, PKK teams facilitate, motivate, monitor and supervise the activities of the PKK at the next lower level. The lowest level is called the Group of Ten and consists of ten households being served by one PKK member. The process of community involvement is usually as follows:

- A meeting is held at village level involving the formal and informal leaders. Health centre staff come and introduce the concept of the integrated service post.
- The communities, with support from health centre staff, conduct a community self-survey with the objective of identifying problems and increasing awareness.
- The results of this survey are presented and discussed in a 'community consensus meeting' in which the whole community is participating. During this meeting priority problems and solutions are determined.

In areas, where the posyandu is well established, volunteer cadres visit the homes of target groups one to two days before the posyandu session, preferably accompanied by the hamlet chief. After the posyandu, a meeting is held to discuss the effectiveness of the preparations that have been made, the implementation and coverage of the posyandu activities that day, and to complete the recording and reporting of the activities of the day.

The posyandu is an evolving strategy. Its aspired role in promoting an intersectoral approach requires strengthening. A recent development is the provision of a reward to the posyandu for identifying illiterate mothers of under-fives. These mothers are then offered literacy training and a non-formal education package for home-industry. Other health promoting activities are being explored.

Sources: Report: Assessment of Integrated Family Health Packages, Parts I and II, 1987.
Halim Kesuma et al. Profile of District Health Services, Sidoarjo District, 1987.

Home Visiting

In some countries, outreach programmes and home visiting are used as an entry point for promoting community involvement in health.

A STRATEGY FOR OUTREACH AND PARTICIPATION IN GUATEMALA

In 1983, the low coverage with essential care attained in Guatemala led to the design of a national operational model of Primary Health Care called the "canalizacion" model. This consists of systematic rounds of household visits and the development of various forms of community participation. The term "canalizacion" indicates the encouragement of people to go to the appropriate health units in demand for preventive as well as curative services.

The implementation of the model starts in the 'department' (region) with a two-day seminar for the professionals, followed by a seminar involving all the staff in each district (about 6 to 10 per 'department'). At the end of each seminar a map is drawn of the catchment area of each health unit, including every house, path, water source, school, etc. On the basis of the maps, the real or feasible catchment area of each health care unit

is decided upon. This catchment area is then divided into sectors which are assigned to a member of staff: a nurse, a midwife or a health inspector. The size of the sectors allows the staff member to visit each house once in a 12-week period by devoting one and a half to two days per week to this field work.

At the beginning of his work, each staff member does two things: he completes a simple census, and he convinces one resident per sector to be a 'health collaborator'. Priority is given to previously trained health promotors or traditional birth attendants. The health collaborators are trained before the first round of visits.

In each home the staff member, equipped with an appropriate kit, and accompanied by the collaborator, does the following

- raising awareness of health needs
- inscription of children under five for immunization
- education in oral rehydration
- referrals
- updating the census form.

As the programme gains momentum in a given district, other activities are gradually added for implementation through home visits: acute respiratory infections, sanitation, growth monitoring, first antenatal control, child-spacing advice.

On the day after the home visits, the staff member returns to the sector to perform the vaccinations programmed on the first day. These are usually done in the house of the collaborator who also goes to fetch any missing children. Those still absent at the end of the session are given an appointment for the following week in the next sector. On the afternoon after the vaccination session, the staff member visits the collaborator and reviews his activities and problems with him.

The results derived from this approach are encouraging: hospital mortality and the rate of hospitalization of children in the relevant departmental hospitals have fallen markedly. Coverage levels for immunization have risen dramatically. Utilization of static health services has also increased.

A gradual upgrading of the education of the health volunteers is contemplated. The model of 'canalizacion' makes it possible for this upgrading to be oriented towards the strengthening of overall community organization and development.

Sources: Development of District Health Systems in Guatemala based on Primary Health Care, 1987.
Montoya, C., Personal Communication.

Programmes for Education, Orientation and Training for Community Involvement

Education and training for community involvement should be considered for three groups: (1) decision-makers and professional staff, (2) community level health workers, (3) community leaders. These three groups are suggested since the content and methodology of the education cannot be universal throughout the health system but must reflect the differing roles and responsibilities in terms of community involvement.

Since, to date, there is a lack of experimentation and practice to show how education and training for community involvement can best be integrated into district health services, the first requirement is a period of research and experimentation to develop the most appropriate content and the best methodologies for orienting health professionals and community level workers. The development of self-management capabilities and the strengthening of local structures should be approached in collaboration with other development sectors and agencies.

SOME IMPORTANT CONCLUSIONS

- **Theory of community involvement in health is ahead of its practice, and there is confusion about its practical meaning.**
- **Community involvement can only occur when certain preconditions are met, most importantly, political commitment and re-orientation of professional staff.**
- **There are important success stories of community participation in small scale projects, often managed by non-governmental organizations. But the mass mobilization required to achieve community involvement on a broad scale usually implies political commitment to participation as a societal goal in its own right.**
- **Homevisiting and collaboration in organizing and financing outreach services have been useful mechanisms for involving communities in health and social welfare in a number of countries.**
- **Research and experimentation are needed to develop the most appropriate content and the best methodologies for orienting decision-makers and health professionals, community health workers, and community leaders to full involvement of communities in health.**

8. Development of Human Resources

Development of human resources for district health systems based on Primary Health Care requires a comprehensive manpower policy for the entire system, from the definition of manpower needs through basic training orientation, career development and working conditions. In the district, it is concerned with the provision of relevant in-service training and support and supervision, and the re-orientation of health workers based on competency profiles rather than on outdated duty schedules. It seeks to narrow the gap between managing and training for Primary Health Care, and to develop procedures, methodologies and materials that fit with the requirements of the district.

SOME KEY PROBLEMS

- **Many continuing education programmes are primarily oriented to offering courses and workshops. Not enough emphasis is placed on in-service training in the workplace through supportive supervision.**
- **Districts are not self-sufficient in providing in-service training. Many training activities in the district continue to be organized and imposed by vertical programmes from the central level.**
- **Job descriptions of rural health workers do not adequately reflect actual tasks and responsibilities.**
- **There are numerous disincentives to working in the district, particularly in remote areas where the need is the greatest. These include late payment of salaries, poor working conditions, missed opportunities for promotion, and inadequate housing.**
- **There is an unmet need at district level for change agents and leaders trained and orientated towards developing Primary Health Care rather than just running health services.**

Developing District Training Plans and Schedules

The need for continuing education in the district has long been recognized. Efforts to develop systems for extending the education of the health worker beyond basic training have resulted in the establishment of national continuing education programmes in numerous countries. However, many of these programmes consist primarily of courses and workshops. Although district health workers are the prime target, districts are not self-sufficient in providing in-service training.

Many districts are more or less passive recipients of training initiatives of centrally directed vertical programmes. In the absence of strategic plans based on problems and training needs identified in the district by the district, training activities are scheduled to suit vertical programme requirements rather than the needs of integrated district health services.

However, in some countries, districts are beginning to look at the development of people in the context of a workplan for the year. The process starts with field visits to health stations to review the functions of different types of facilities and analyse the tasks actually performed by the health workers serving in these facilities. With this information in hand, the district teams determine the nature and priority of training needs and develop annual plans and schedules for in-service training. Vertical programme training is then organized to fit into these plans rather than the other way around.

COORDINATION OF DISTRICT TRAINING IN UGANDA

Uganda launched its Continuing Education Programme in 1983. The major continuing education approaches were

- refresher courses
- establishment of district libraries
- correspondence courses
- management training
- curricula revision and tutor upgrading
- development of health learning materials.

At the same time, a number of vertical programmes started operating in Uganda, including an Expanded Programme on Immunization, an Essential Drugs Programme, a Family Planning Programme and a Diarrhoeal Disease Control Programme. Each of these programmes had its own training curriculum and learning materials. In each instance, the target group was the district health team. As a result, district health teams soon found themselves flooded with training workshops. By late 1985, the Ministry decided the situation needed remedial action and organized a workshop to discuss and develop a strategy for coordinating all the diverse training inputs to the district. An agreement was reached to combine resources and materials and hold combined workshops, which were called Mid-Level Managers (MLM) courses.

The Centre for Continuing Education was renamed Centre for Health Manpower Development. Its brief was extended from running the national continuing education programme to planning human resource development with the districts and assuring effective coordination of training initiatives by vertical programmes, non-governmental organizations and other institutions.

Sources: AMREF and Ministry of Health, Uganda, Training Reports, 1984–1986
Annett, H., Personal Communication.

Narrowing the Management — Training Gap

Strengthening district health managers' ability to plan and implement in-service training and to link this with improved support and supervision also serves to narrow the traditional gap between management and training. Members of district health management teams, with support from regional training institutions and other resource centres, become trainers and facilitators in manpower development efforts that are increasingly based in the workplace. As a result, the overwhelming emphasis on workshops and seminars prevalent in many countries is decreased and the institutional capacity to provide continuing education and in-service training in the district is enhanced. When linked with problem-oriented action research, training also becomes an effective tool for broad-based management development (see also chapter four).

MANAGEMENT TRAINING IN BOTSWANA

Following the decision to decentralize health services in Botswana in 1986, a training programme for district health teams was developed.

The purpose of the programme was twofold. It served as a forum for effectively disseminating information about the rationale and objectives of district health systems based on Primary Health Care goals, and of the proposed roles and responsibilities of the district officers under the new decentralized system. It also aimed to impart the necessary knowledge and skills for district teams to perform these roles.

A Central Core Team was constituted with officers from the Ministry of Health who later formed the Primary Health Care Support Unit, from Unified Local Government Service, from the Ministry of Local Government and Lands, and from selected districts in the country. One of the responsibilities of this team was the training of district health teams for their new roles and responsibilities.

Participants received a workshop preparation manual well in advance. This preparation manual contained information on the new management support systems for PHC and on the proposed new district health structure, including job descriptions and a functions analysis of the job descriptions. It also included notes on problem analysis, planning, supervision and communication. Participants were expected to meet prior to the workshop to undertake on their own an exercise on problem identification.

At the workshop, detailed analyses of the problems previously identified were carried out in groups, followed by plenary discussion.

The final exercise was the design of a training programme for district health staff and an orientation programme for non-health staff.

Workshops were carried out in all districts throughout the country. In addition to informing and training district staff, the Central Core Team benefited from the ideas and propositions for the new decentralized system put forward by the participants. Many of these ideas were considered and incorporated into the evolving structure of the PHC programme. The workshops had thus contributed to both manpower development and systems reform.

Sources: Pederson, J.V., Report on the Decentralization of Health Services, 1986.
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WHO Travel Reports, 1986.

Exploring and Developing Innovative Approaches to Continuing Education for District Manpower Development

The 1986 AMREF Workshop on Continuing Education in Eastern and Southern Africa suggested that there is inadequate knowledge of the relative merits of different continuing education approaches and methods. One of the recommendations of the workshop was to explore strategies that do not rely solely on the development of skills and knowledge, and to move away from courses towards support and supervision in the workplace.

A number of innovative methods are now at various stages of development and implementation. For example, Activity-Based Learning (ABLE) is a method for continuing the education of health staff which combines periodic, in-service training workshops with regular supportive supervision. It is based on the

recognition that, however successful a workshop, health staff return to their stations and often fail to implement what they have learned. The activity-based learning process attempts to bridge this implementation gap. The emphasis is on process, because learning continues until the activities are actually implemented. During the learning process, the difficulties and obstacles which are preventing implementation are discussed and overcome.

The Health For All Leadership Development Initiative was launched by WHO in 1985 to support countries in taking the step from policy to action in the pursuit of the Health For All goal. Its principal aim is to create a critical mass of people capable of providing leadership within the Health For All movement in each country. The first target has been the national level.

The emerging leaders should be able to

- identify central issues affecting implementation of their national strategies;
- specify their own personal role in resolving those issues which fall within the scope of their responsibilities;
- define strategic actions to resolve these issues;
- initiate the process of change required;
- involve and mobilize others;
- support further leadership development.

With increasing recognition of the need to develop leaders and change agents for the district, there is a strong case for adapting leadership training for policy-makers and national decision-makers to this purpose.

TRAINING OF AWRAJA HEALTH MANAGERS IN ETHIOPIA

The training of medical graduates as district health managers in Ethiopia is a first attempt to develop leaders and change agents for the district.

In designing this new course, the aim has been to prepare a new Primary Health Care manager to meet the needs of the Awraja health administration. The new district health managers are expected to be much more than administrators. They are to be leaders, trainers and a source of inspiration for the development of Primary Health Care.

The programme was started against a background of a hospital and curative-oriented undergraduate course for physicians. In contrast to traditional curricula, the Awraja health manager's training programme is competency-based, taking into account the job description.

Awraja health managers will

- work with mass organizations in the Awraja to identify health related problems and advise on the means of overcoming them
- organize, manage and administer the health services of the Awraja so as to ensure maximum coordination of the available services and to achieve optimum coverage, efficency and effectiveness
- plan the health services in the Awraja
- ensure coordination of intersectoral health-related activities
- develop and/or strengthen the mechanism for collection, analysis and interpretation of information necessary for health planning and management, including monitoring and evaluation at all levels in the Awraja
- participate in the planning and running of training for professional and other cadres of health staff in the Awraja.

Above all, the training stresses the importance of the Awraja health manager as an agent of change. Through discussion, persuasion, and mobilization, he must bring about a commitment to Primary Health Care on the part of health professionals, members of other key sectors, and the mass organizations.

In order to impart the knowledge and develop the skill needed to carry out these functions, the course emphasizes the concept of learning-by-doing.

The first part of the course consists of theoretical training in planning, epidemiology, management and communication, interspersed with two months of practical field work, with emphasis on designing surveys with the involvement of communities and identification of priority problems.

During the following one-year period, the students become acting Awraja health managers and are expected to put into practice what they have learned and to lay the foundations for the re-organized Primary Health Care system at Awraja level. They also undertake a research project which forms the basis of their dissertation, leading to the award of an MSc. in Community Health.

Source: Ethiopia: Strengthening the District Health System to meet the Challenge of Primary Health Care, 1987.

SOME IMPORTANT CONCLUSIONS

- **The identification of leaders and change agents, and the development of appropriate methods for orienting them to Primary Health Care and for fostering the essential qualities they need to guide and inspire are of paramount importance in the development of district health systems.**

- **The long-term effectiveness of training depends critically on the application and further development of activity-based and problem-oriented methods, and on concomitant improvements in the working environment.**

- **Regular support and supervision visits offer excellent opportunities for in-service training.**

- **The proliferation of training workshops organized by individual vertical programmes for district health teams and other district health workers is increasingly recognized as a problem. Countries are beginning to take steps to coordinate vertical programme training with a view to developing integrated district training programmes.**

PART C
TOWARDS A FRAMEWORK FOR ACTION

Part C
Towards a Framework for Action

In the last part of this paper, we use our conclusions from the preceding chapters to propose directions towards the formulation of a framework for action to guide both planners and implementers. These directions are congruent with and build on the recommendations that are recorded in the Harare Declaration of August 1987.

We also propose a set of critical considerations that need to be addressed in the development, implementation and evaluation of any strategies adopted for strengthening district health systems based on Primary Health Care.

Directions for Strengthening District Health Systems

Decentralization and National Support

National governments need to adopt policies that support the development of district health systems; allowing flexibility for local action while ensuring equity between districts.

Ministries of health need to develop broad guidelines that specify the roles and responsibilities of the centre, the region and the district. These guidelines should then be reviewed regularly to allow modification on the basis of lessons learned in the implementation of district health systems.

Districts should be given sufficient authority to enable them to manage financial and human resources allocated to and raised by them, within a national policy framework but responsive to local needs and conditions.

Organization, Planning and Management

Districts need to develop a planning process to define objectives and set targets with emphasis on those families and communities most at risk.

Roles, goals and procedures need to be reviewed and adopted by district health teams. A participatory managerial style that facilitates a free flow of information from all directions will enhance this process.

The role and functioning of district hospitals in the context of Primary Health Care should be reviewed and redefined, and hospital staff oriented accordingly.

District health information systems need to be developed to provide data for monitoring health problems and resource utilization. Emphasis should be placed on decision-linked information that will be used in the district for the district.

Problem-oriented action research needs to become an integral part of district health management; to carry out situation analyses, field studies on operational problems, and evaluations of district health activities and programmes.

Resource Allocation and Finance

Financial planning and management needs to be strengthened to provide reliable information for the review of the cost and effectiveness of health activities and outputs, leading to improved use of available limited resources.

Resource allocation priorities need to be reviewed and adjusted in accordance with stated Primary Health Care objectives, both at national and at district levels.

Options for financing health services in addition to traditional central and local government funding need to be considered and implemented. Resources can be mobilized through user charges, social security and pre-paid schemes. Better use needs to be made of resources available from communities and non-governmental groups.

Intersectoral Action

National governments and district administrations need to create mechanisms to give health concerns higher priority on the agenda of district development and assist each sector to define its role in health activities.

Community Involvement

Education, orientation and training for community involvement should be directed at decision-makers and professional staff; community level health workers; and community leaders.

National governments need to demonstrate the political will to support community involvement in health and to promote self-reliance by strengthening the knowledge and skills of communities for solving health and development problems.

Development of Human Resources

Districts need to take an active role in determining training and staff development strategies and schedules. Review of learning needs and coordination of training inputs, particularly from vertical programmes, should become a routine part of district health management.

Continuing education for rural health workers needs to move from the current emphasis on workshops and seminars to training in the workplace through supportive supervision.

District leadership for Primary Health Care should be developed through orientation, training and continuing education of key individuals.

Strategies of Action

To pursue these directions, we need to choose the most appropriate and effective methods of action. To a large extent, possible technical solutions have been provided in the country experiences presented in this paper, and are contained within the recommended directions. At the country level we have advocated

* policy action
* action research
* management systems review and development
* activity-based learning
* leadership training.

In order to stimulate and sustain action at the country level, we are further advocating that at the international level the most urgently needed support be effected through

* mobilizing resources for strengthening district health systems
* facilitating exchange of information about district development.

Towards that end, WHO has given its pledge at Harare to support

* research and development in selected districts across the world
* country-wide action for district development
* promotion, training and information exchange for district health systems
* mobilization of additional human, technical and financial resources for the district.

As countries gain experience in implementing the proposed and other strategies for strengthening districts, WHO will assist in documenting these country experiences so that countries may learn from each other. Such analyses will include not only details of the technical solutions, but examine the processes by which change has been initiated and review the context within which it has been possible to successfully implement and sustain the results of these strategies.

Part C
Towards a Framework for Action *(continued)*

Five Critical Considerations

Finally, with action becoming more focused on the district, we suggest that there are five critical considerations that all countries and donors need to take into account so that the district can become and remain a viable entity for managing and implementing Primary Health Care. These are:

1. **Experimentation and Learning**
   The willingness and ability of health systems to learn from experience is a critical factor in the implementation of the complex set of ideas and elements that is Primary Health Care. The development and strengthening of district health systems based on Primary Health Care is at an early stage. In this situation, the conventional 'blueprint' approach to development in which all components of a strategy are planned in detail and then followed rigidly during implementation, is not satisfactory. There is instead a need to explore innovative strategies and to analyse what lessons are emerging as these strategies are being implemented. The planning of interventions needs to become an ongoing process in which there is plenty of room for revising, adapting and refining the plans as implementation progresses. It is becoming increasingly evident that the most innovative and successful initiatives have been developed in the spirit of experimentation and learning over extended periods of time.

2. **Sustainability**
   Another principle concerns the long-term sustainability of solutions and with it the methods for institutionalizing capabilities required to implement them. Some of the solutions adopted in the past have proved effective in the short run but require never-ending external inputs to sustain the results. Institution-building and development of the people that need to carry on long after the initial project framework is dissolved are essential ingredients of any viable strategy. This may mean forfeiting apparently speedy solutions for the sake of building up potentially self-reliant systems.

3. **Replication and Expansion**
   As we advocate experimentation in pilot districts, model districts, demonstration districts, 'phasing-in' districts, or 'development areas', the question of replicability is yet another concern. There is no shortage of interesting small-scale pilot projects that have never been implemented on a national scale. There are many reasons for this: either the required recurrent resources were not available, or the project was not adequately monitored and the applicability of the results and findings for wider application was not obvious, or the project was 'owned' by an external agency that did not create the political will to adopt the demonstrated strategy, however successful. What will work, adapt and endure will differ according to the circumstances, but in each instance, clear decisions have to be made about the amount of additional resources used during the trial of innovative approaches.

4. **Systems and People Development**
   Another important principle in paving the way for the development of effective district health systems is that structural reform as well as additional skills are required. Addressing the development of both systems and people is critical because attitudes and practices are not likely to change in a lasting way unless changes in the working environment and in the management system are effected as well.

5. **System-Wide and Systems-Based Change**
   As we describe and analyse the components of the district health system and the interventions that may help to strengthen them, it is evident that each of these components (or sub-systems) is related to all the others. Although any one of them can serve as an entry point for introducing change, it is system-wide change that is usually needed to strengthen the performance of the district and to promote health. Changes in one part of the system may also have positive effects on another part of the system, but they may equally cause the kind of change that is not intended, wanted or needed. Therefore, we must be prepared to carefully monitor and deal with all aspects of the district health system.

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The publications and papers listed in this bibliography cover primarily source documents but include some relevant general reading as well. Part A lists works in alphabetical order according to author, while Part B contains documents and publications of no named author in alphabetical order of their titles. Further information concerning those titles marked with an asterisk may be obtained by writing to the Division of Strengthening Health Services, District Health System Group.

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